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THE PLANNING AND MANAGEMENT OF HEALTH FOR DEVELOPMENT:  
A MODEL FOR ZIMBABWE

by

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Thesis submitted for the degree of PH.D of the  
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TITLE:

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SUMMARY:

In this thesis, I view the historical background of Zimbabwe to show the patterns of traditional life that existed prior to settlerism. The form, nature, pace and impact of settlerism and colonialism up to the time of independence are also discussed to show how they affected the health of the population and the pace of development of the country.

The political, social and economic underdevelopment of the African people that occurred in Zimbabwe prior to independence was a result of deliberate, politically motivated and controlled policy initiatives. These led to inequitable, inadequate, inappropriate and inaccessible health care provision. It is submitted that since it was the politics that determined the pace of underdevelopment, it must be the politics that must be at the forefront of the development strategy adopted.

In the face of the armed conflict that existed in Zimbabwe, existing frameworks of analyses are shown to be inadequate for planning purposes, because of their inability to provide indications about the stability of future outcomes.

The Metagame technique of analysis of options is proposed as a methodology that can be applied in such situations. It rejects deterministic and predictive models as misleading and advocates an interactive model based on objective and subjective valuation of human behaviour. In conclusion, the search for stable outcomes rather than optimal and best solution strategies, is advocated in decision making in organisations of all sizes.

KEY WORDS:

Stability, outcome, equity, decision-making, analysis.

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INTRODUCTION

In this study, I submit that the Rhodesian Health Service was inequitable, inadequate, inappropriate and inaccessible for the majority of the rural African population by deliberate political design.

I further submit that it was the predominance of political factors that conditioned and determined the pace of proletarianisation and peasantisation, summed-up as underdevelopment, that occurred in the country. The extent of the underdevelopment was most manifest in the state of ill-health of the majority of the affected population. Through tackling the problems of health as broadly defined, it is submitted, the process of real development can be embarked on. Health can be an 'entry-point' if not a 'potent-level' for development.

Whereas existing frameworks of analysis enable us to understand what occurred, how and its impact on different population groups, they fall short on perceiving future courses of action to remedy the situation. The experiences of Zimbabwe are recounted to demonstrate this universal phenomenon. The planning for a developmental process by nature is bound to create a situation of conflict, since it requires that the elite groups relinquish some of their power and wealth for the good of all. Often this will not be voluntary, as shown by the conflict that emerged in Zimbabwe up to 1980, in the struggle for political power as the prelude to 'growth with equity' (development).

The study concludes that:

An empirico-historical analysis is important as the first step in understanding the nature of the politico-socio-economic forces that interact to produce underdevelopment;

Underdevelopment is characterised by ill-health, poverty, lack of political power and ignorance among the majority of the population in Third World countries, often the result of maldistribution, rather than lack of resources;

Planning for health can be 'an entry-point to', if not a 'potent-lever for', development. Planning of health for development concerns itself ultimately with conflict resolution. It has to address itself to the conflict that arises from attempts to redress gaping differences in health status and access to health care;

Planning of health for development, besides having to deal with levelling out imbalances in resources distribution between curative institutions, must institute integrated comprehensive care that emphasises prevention, promotion and rehabilitation;

Inevitably, it must propose a decision-making machinery, a management form, which can successfully address itself to all the above issues and actually initiate positive measures for the care of the population and development of the nation, through the involvement of the masses who are the beneficiaries of the development;



In the light of the failure of conventional modes of planning, game theoretic techniques like analysis of options are useful aides to decision making within these complex situations;

Analysis of options' ability to predict outcomes only if those are stable, provides planners and decision makers with a tool of analysis that will enable them to, take a realistic long-term view (what 'should be' rather than 'ought to be') of their situations and organise themselves in a more informed manner.

The study is in four parts broken into eight chapters and a conclusion. Part I lays the foundation of the study and is broken into Chapters I to IV.

Chapter I examines the historical background of the country and attempts to answer the questions: What was Zimbabwean society like before the intrusion of settlerism and colonisation? What was the mode and impact of European settlement? How did this influence future policy formulation and future relation between the indigenous population and the settlers?

Chapter II reviews the existing frameworks of analysis that may be used in the quest for understanding Zimbabwe's development path. The discussion seeks to set out the conceptual frameworks within which events that occurred in Rhodesia can be understood as part of a universal pattern. It attempts to answer the question: In what framework can one seek to understand the events which occurred up to

the present situation? In the process, the issues that surround the underdevelopment and development debate are revisited and the thesis put forward that, health can be an 'entry-point' to if not a 'potent lever' for development.

In Chapter III, the political economy of Rhodesia is examined with the view to determining the origins and growth of conflict in the country. The questions posed include: What was the nature of the policy that emerged from a marriage between a colonial Government and a Company Board of Directors? How did the political and economic motivations interact in the process of class formation in the country? What role did the State play? The discussion shows the extent to which the African population was underdeveloped and how it manifested itself through the deterioration in African health in the face of dependent economic growth. More significantly, the conflict over land, how it sharpened and ended in open confrontation, is analysed.

In Chapter IV an attempt is made to answer the questions: Is it possible to analyse the growth of the health services provision in a bid to demonstrate the inequity that was created during the industrialisation and economic growth drive of the colonial capitalist state? To what extent did the differential approach to economic and political issues between the two races lead to the perverse growth of the Health Services? Can one demonstrate that the health services inadequacies in fact mirror deeper seated political, economic and socio-cultural distortions the result of capitalist penetration?

Part II examines the problems of health and the health care sector in Zimbabwe under Chapter V and VI respectively.

In Chapter V, the principal determinants of health and the extent of the inequalities between social groups are examined. The thesis is put forward that health problems were the result of a proliferation of inequalities \_ political, social and economic \_ across the sectors, which accumulated over time but whose magnitude reached crisis levels at the peak of the war, in 1979. The differences in health status between the whites and blacks, urban and rural populations, and people in the modern and peasant sectors are observed to be the result of the above. It is concluded that health, far more than being a medical problem, is a developmental matter requiring a multi-sectoral interdisciplinary approach which upholds equity objectives. In the solution process to ill-health therefore, emphasis should be laid on the importance of the socio-political factors, because of their insistence on distributive justice.

The main thrust of Chapter VI is to what extent the health care sector caters for the needy urban-worker and rural-peasant communities? The issues involved are discussed under six sub-headings: the fragmentation of the health care sector, the preventive-curative dichotomy, the inequitable distribution of the health services, racial and economic discrimination effects on access to care, and the ineffectiveness of the health care organisation. It is concluded that far from the health care sector assisting in closing the gaping differences in health status, it has perpetrated them by overproviding



for the rich-urban based elites. Social class and political power continued to influence and determine the selective provision of care in the health system prior to 1980. Far more than scarcity of resources, maldistribution of resources contributed to poor provision of care in Zimbabwe.

Part III is made up of Chapter VII which concentrates on the proposed methodology \_ the metagame technique of analysis of options. Its method of application is demonstrated both at the international and national level, before a discussion of its advantages and disadvantages in planning and management under conflict.

Part IV is the final part and is made-up of Chapter VIII and Chapter IX which is the conclusion.

CHAPTER I      THE HISTORICAL APPROACH

INTRODUCTION

An examination of the historical background of Zimbabwe is crucial to the understanding of the material base and the superstructure which will be examined in this study. An historical analysis lays down the foundation for the parts that are concerned with concepts, method and application. Without putting the historical aspects into perspective, it becomes very difficult to travel with the reader on this unique journey towards 'equity in health'. Indeed it is a truism that the past carries in it lessons from which we must learn in order to appreciate the present and to change the future. The question to be posed first is: what was Zimbabwe society like before the intrusion of colonialism in the last decade of the 19th century?

ZIMBABWE BEFORE THE SETTLERS:

The Country

Zimbabwe was marked by the natural boundaries of the Zambezi river in the north, the Limpopo river in the south and the Kalahari Desert in the west. The boundaries that now exist, with Botswana on the west and Mozambique on the east, were demarcated by the Imperial powers in the late nineteenth century as Southern Rhodesia. In the East, tribal ties spill over the boundaries. The country covers some 150,000 square miles or 96<sup>7</sup> million acres.

The Zimbabwean traditional society was made up of agriculturalists, unique in their own way. Two major tribal groupings inhabited it with smaller tribes distinguishable by the areas they now occupy on the fringes of the country. Map 1.1 shows the division of the country into the groupings, with the Shona and related dialects, constituting about eighty per cent of the population, and the Ndebele fifteen per cent.<sup>1</sup> A quick look at the geographical Map 1.2 shows the close correlation between the areas inhabited by the main tribes, and the good climatic conditions.

Being wholly within the tropics, the country enjoys a rich and varied natural heritage which is unequalled by that of any region of similar size in tropical Africa.<sup>2</sup> The country is divided into natural or physiographic regions on the basis of relief, and the terms highveld, middleveld and lowveld are ascribed to these regions. The difference in altitude and the accompanying climatic variations of temperature and rainfall, lead to this classification, as Table 1.3 shows. The importance of these factors will be referred to throughout this study because they affected the white settlement pattern initially, leading to conflict with the major tribes, and the distribution of facilities later.

---

1. Palmer, R. (1977) "Land and Racial Domination in Rhodesia". Heinemann Educational Books Ltd., London. p.5.

2. Kay, G. (1970) "Rhodesia, A Human Geography". London 1970.

MAP III. TRIBAL GROUPINGS IN ZIMBABWE.



Aston University

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MAP 1.2: THE PELTET MAP OF ZIMBABWE.



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TABLE 1.3 REGIONAL CLASSIFICATION AND RELIEF AND CLIMATIC CONDITIONS

REGION	HEIGHT ABOVE SEA LEVEL	PERCENTAGE OF TOTAL COUNTRY AREA	AVERAGE RAINFALL	TEMPERATURE
HIGHVELD (EASTERN BELT)	OVER 5000'	) ) ) 25	40"	COOL & MILD
HIGHVELD	4000-5000'	) )	32"	WARM - COOL
MIDDLE VELD	3000-4000'	40	24"	COOL & MODERATE TO HOT SUMMERS
LOW VELD	BELOW 3000'	35	16"	HOT - UNBEARABLE IN SUMMER

SOURCE: G. KAY: A HUMAN GEOGRAPHY (RHODESIA) 1970

## THE SHONA

The Shona have lived and occupied the country for about fourteen centuries. Palmer (1977) notes that until 1820 they were the undisputed masters of the middle and high veld of the country. Since the lesser tribes (Tonga, Venda, Hlengwe) occupy the fringes of the country which are hot, dry and rugged and unsuitable for cultivation and habitation, it is reasonable to assume that they may have been pushed out by the numerically more Shona. The most renowned of the Shona Kingdoms were Mumumutapa and Rozvi Empires, the standing reminders of whose rule have defied time in the form of the Zimbabwe ruins in the South-East of the country. Beach (1974) has written that they were descendants of the creators of the most impressive Iron Age material culture in southern Africa.<sup>1</sup>

Palmer states that the Shona were agriculturalists who enjoyed a degree of prosperity which belies the standard picture of a people utterly demoralised by raids. They used 'land rotation cultivation',<sup>2</sup> whereby pieces of land were cleared and cultivated then left fallow to regain fertility. This accounts for the dispersion of Shona villages and where the raids occurred, siting was

---

1. Beach, D.N. (1974) "Ndebele Raiders and Shona Power", Journal of African History, 15.

2. Allan, W. (1956) "The African Husbandman", London 1956. He uses this term as opposed to the commonly used 'shifting cultivation', which does not bring out the skill and coming to terms with nature; which led to its development and merely implies haphazard behaviour.

usually on 'kopjes' (rocky hills) which were easily defensible. Because land was abundant, this method worked very well and prevented soil erosion. The introduction of village lines, planned setting of villages in line formation, contrary to more recent assertions; as part of the Native Reserves (TTL's) as they were called, went contrary to traditional patterns of living. The Shona produced a wide variety of crops as staples, which they supplemented with a variety of fruits and game, fish and livestock. The dietary variety and richness must have made them physically and mentally very healthy people. Their other activities bear testimony to this assertion. These included working of iron for agricultural tools, weapons, wood carving, baskets, nets and cloth making, which they traded. Gold mining and trading, a twelfth and fifteenth centuries activity, continued, though it was in the decline; this accounts for the Shona grief when the settler occupation ended their trade to the East. Earlier writings on Shona trade observed that:

"Europeans were besieged<sup>1</sup> by people offering them a wide range of goods".

Phimister came to the conclusion that,

"the Shona made intelligent use of their harsh environments".

---

1. Phimister, I.R. "Peasant Production and Underdevelopment in Southern Rhodesia, 1890-1914", African Affairs, 73, 291.



It is because of this background that they were very responsive to the new markets created by the arrival of the Europeans. This brief look seems to give some credence to the nineteenth century studies which observed that:

"the tribesmen are polyfunctional". (Kay).

In 1820, the Ndebele (Nguni) invaded the country and around 1837, under Mzilkazi, settled in the West from which they raided the neighbouring Shona. The most concerted effort to dominate the Shona was in 1860-73 during which time,

"a number of Shona-groups fell tributary to the Ndebele";

but after 1877, their power was on the wane in the face of a massive influx of guns which strengthened the Shona capacity to resist.<sup>1</sup> It is not surprising therefore that Europeans who came into contact with the vassal groups of Shona stereotyped the whole tribe as:

"a weak, cowardly people,"

who would obviously welcome them as protectors against

---

1. Palmer, R. p.9 observes that the history of Shona-Ndebele relations is being rewritten which includes some of these views.

the supposedly dominant Ndebele.<sup>1</sup> To understand how some of the above aspects could be true, one must attempt to analyse the social organisation of the Shona.

It is notable that among the Shona, each chief was paramount in his area. Under him were sub-chiefs and headmen. In the same way that he had a court (Dare) made of the 'wisemen' who advised him on all affairs, those under him also had this structure. Selection was by the people as a whole within a village and representatives of villages at the higher level. In some cases it was by co-option at the display of individual skills and bravery in battle. Some villagers made their names through expertise in iron tools making, carving, farming, etc. To the extent that this gave status, there could be said to have existed differentiation in this society.

Shona writings also indicate servant status for those who were captured in battles with other tribes.<sup>2</sup>

Indisputable however is the fact that Chieftaincy was by patrilineality. Though materially the Chief owned more, the Shona customary law regarding land,

---

1. Palmer, R. (see (1) previous page.

2. Chidzero, B. in his Shona novel and Chakaipa, P. all imply in their fiction novels that the Chief's court had servants.

stipulated that it belonged to the tribe and the chief was entrusted with the authority to administer it on behalf of the tribe in a just and fair manner.

(Kay, G. 1970 p.29)

Because the various chieftaincies had no overlord status, although they consulted on matters of mutual interest, (eg in 1896 before deciding to rise against the settlers in the Chimurenga Wars) writers referred to them as:

"a politically fragmented people" (Palmer 1977 p.10)

Ranger (1976) however observes that they retained in the Mwari cult and through their spirit mediums, a degree of religious cohesion which provided a vehicle of commitment to resistance during the Chimurenga Wars 1896-97.<sup>1</sup> Palmer concludes that the Shona were a good deal more resilient than the Europeans imagined.

---

1. Ranger, T.O. "Revolt in Southern Rhodesia, 1896-97" London, 1976.

## THE NDEBELE

The invading Nguni of 1820 proceeded further North into Zambia and were followed by Mzilikazi, who had fled from Shaka in 1822, having failed to surrender cattle captured in a raid. He settled with his Ndebele in 1838, around Bulawayo, on the highveld:

"free from tse-tse fly and ideal for cattle".  
(Palmer p.17).

Recent history writers have tried to do away with earlier prejudices of nineteenth century writers who portrayed the Ndebele state as militaristic. Cobbing has attempted to 'demilitarise' and 'decentralise' Ndebele history.<sup>1</sup> Whereas Kay (1970) observes that Mzilikazi continued:

"the Zulu habit of supplementing cattle-rearing and a limited crop husbandry with a military economy based on plunder and tribute".

Cobbing contends that this is an exaggeration. He describes Ndebele settlements in the pre-colonial era

---

1. Cobbing, J.R.D. "The Ndebele", "The Evolution of Ndebele Amabutho", Journal of African History, 15, 1974, 608.



as:

"small scale, probably averaging from about fifty to two hundred people. Villages were collected together in clusters and the outlying political unit of the state was not the 'regimental' town, but the partially decentralized chieftaincy.....

..... which contained several villages. One family supplied a succession of chiefs within a chieftaincy according to strict laws of patrilineality.....".<sup>1</sup>

The question of raids, as seen earlier on above, was a feature prior to 1877, limited to the Shona chiefs in the West who sometimes paid tribute and other times resisted.<sup>2</sup> Tribute took variant forms ranging from skins, feathers, hoes, tobacco, grain to labour. It was on these raids that some Shona were incorporated into the Ndebele forming the Holi or 'serf caste'. The other two castes were the Enhla, absorbed in Transvaal and the Zansi, the original Nguni stock. Bhebe<sup>3</sup> writes that the Holi:

"comprised a numerical majority and exerted significant influence on Ndebele society".

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1. Cobbing, J.R.D. (see (1) previous page).
  2. Beach, D.N. "The Shona and Ndebele Power", University of Rhodesia, Department of History, Henderson Seminar No.26 1973.
  3. Bhebe, N.M.B. "Some Aspects of Ndebele Relations with the Shona in the 19th Century" Rhodesian History 4, 1973.

To the extent that clearcut distinction existed amongst the Ndebele, some form of feudalism could be said to have existed. Within the larger villages are found, a royal field and granary to supply the king with food whenever he visited; while the Holi

"had to hoe in the King's fields, before they were allowed to start on their own".<sup>1</sup>

The existence of this class-hierarchy provided breeding ground or a good starting basis for wider class differentiation on contact with the capitalist mode of production. This feature of Ndebele society is very important in the analysis of community organisation for involvement in developmental planning and implementation. Since bottom-up planning calls for all the people's efforts, there is bound to be resentment or non-subordination to Holi initiatives by the two upper classes and vice versa.

Given, as Bhebe observes above, that the lowest caste are in the majority, democratic planning processes will inevitably result in the majority becoming more involved and subsequently in control. The importance of the likely impact of these divisions to development planners needs identification, hence the need to disclose these features at the beginning of the study.

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1. Jones, N. "Rhodesian Genesis", Bulawayo, 1953, p.116.

Like the Shona, the Ndebele were also Agriculturalists, rearing cattle, growing maize, other grains and cotton (for garments). Accounts of their regional trade with other tribes in tobacco, grain and copper are given by Kosmin.<sup>1</sup> The reason attributed to this trade was periodic drought, which could also be easily the cause for the earlier raids (Bhebe 1973). The king was trustee of the land for the whole nation. He assigned arable and grazing land for the various villages and when these were exhausted they moved on. The social cohesion was kept by the practice that:

"they would build their huts (at the new sites), in the relative position they occupied in the old and the<sub>2</sub> lands would be distributed in the same way."

This was aimed at ensuring that as little disruption to the social pattern of life was caused as possible. Each family cultivated its own plot. The husband was involved with sowing and the harvest but spent most of the time hunting and doing other craft work.

Despite, as we have seen above, the full knowledge that the Ndebele did not control the whole of Zimbabwe, both

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1. Kosmin, B.A. "The Inyoka Tobacco Industry of the Shangwe people, A case study of the displacement of a Pre-colonial Economy in Southern Rhodesia, 1898-1938," African Social Research, 17.
  2. Helm, C.C. (1904) Evidence to South African Native Affairs Commission, 1903-5, Vol V, Cape Town. This may be said to have minimised the chance of upward mobility.



Lobengula and Cecil Rhodes of the British South Africa Company were prepared to pretend that he did and signed agreements over mineral rights that included Mashonaland. It is possible Lobengula might have hoped that the Column in 1890 would bring the Shona to their knees and on the other hand, Rhodes wanted to avoid tracking the numerous Shona chiefs with independent authority over their areas. This was to anger the Shona to a point of going to war with the whites - settlers and company employees.

What conclusions can one draw on pre-colonial patterns of life and social organisation? Foremost as Phimister noted (quoted on p. ) is the fact that the African was living in equilibrium with his environment. It can even be said that he had tamed the environment to meet his needs. A lot depended on land availability and social coherence was held uppermost within chieftaincies. Some form of differentiation existed but it was more pronounced among the Ndebele where one could discern feudalistic patterns. The people throughout the country performed varying functions depending on the skills or the dictates of the weather, but everybody took part in harvesting. All had an interest in it, for the husband would want a surplus to go and trade, and the wife to purchase or exchange for household items.

The discussion above and writings by a good number of people seem to uphold Mason's (1958) view that:



"tribal life did provide a deep if intermittent satisfaction".

Claims that:

"poverty is endemic....." (George Kay),

from the above account, clearly are features which were uncommon prior to the coming of the whiteman at the end of the 19th century. Since, even the Ndebele used granaries to store grain during bountiful years to see them through the drought.<sup>1</sup> The favourable rainfall and climate (including rich soils) of the highveld assured the people of reasonable harvest. Palmer writes that the accounts by travellers of East and Central Africa in the 19th century related:

"evident agricultural prosperity of many of its peoples and the great variety of produce grown together with the volume of local, regional and long-distance trade and the emergence of a wide range of entrepreneurs".

This shows the extent of the internal dynamic of the African indigenous population before it was destroyed by the coming of the settlers - the advent of colonialism.<sup>2</sup>

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1. Thomas, T.M. "Eleven Years in Central South Africa", London 1873.

2. This aspect is the main theme of Chapter III, suffice here to demonstrate that the societies had it in themselves to evolve and transform into higher modes of production.

The above account of traditional society hardly gives any credence to the assertion by Jollie (1932) that:

"Africa before the white man came was a shambles",

nor is it anywhere near Hanna's (1960) assertions of an

"almost all-inclusive reign of barbaric brutality".

As we discussed at length, the earlier Ndebele threats had waned by 1877 because the Shona trade had enabled them to build a lethal arsenal.

One then has to examine what it was about the white settlement pattern that led to the intolerable and despicable state the African indigenous population found itself in, by the last quarter of the twentieth century.

#### EUROPEAN SETTLEMENT

The accounts cited above on African trade in beads, guns, grain and livestock in the East seem to suggest that the Portuguese and the Arabs were involved in Zimbabwe long before even the hunters and missionaries set foot on its soil. It is however writings and accounts of 'Mashona Goldfields' by hunters and travellers like Henry Hartley and Carl Mauch which attracted interest. This interest was heightened by the

Rand discoveries of gold, which gave economic power to the Afrikaners. Now they could back their political demands with economic pressure. This boer strength was seen as

'a threat to British supremacy'

by the British in South Africa especially in the Cape Province and Natal.<sup>1</sup>

"... the development of the Rand profoundly altered the situation for it brought political as well as economic motives into play."

It was Cecil John Rhodes who took the initiative and argued for the exploitation of the 'Second Rand' north of the Limpopo, as the surest way of guaranteeing British supremacy in South Africa and of preventing the rich deposits from falling into the hands of the Portuguese or the Transvaal boers. Since the British government did not show much interest, Rhodes, who had the money and the men, obtained a Royal Charter for his British South Africa Company in 1890 and started the Administration of Mashonaland.<sup>2</sup> But what type of men did Rhodes get together and how did he get them to accept moving into Southern Rhodesia? What was their settlement

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1. Palmer, R. p.12.

2. Ibid. p.13.



pattern? What effect did it have on the indigenous population?

The missionaries were the first groups of people to set up permanent residence in Zimbabwe when Moffat was allowed to open a mission at Sanyati.<sup>1</sup> Palmer states that T.M. Thomas, a missionary who spent the years 1859-70

"vainly endeavouring to convert the Ndebele"

wrote glowing reports on their crop farming. The pioneers who entered the country in 1890, attracted by the British South Africa company (B.S.A.Coy), had very clear motives summed up as:

"to make money and lose no time about it".<sup>2</sup>

The Pioneer Column itself was made up of 196 pioneers and 500 police, but by 1896, there were approximately 5000 Europeans; a number which doubled to 11,000 in 1901.<sup>3</sup>

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1. Kay, G. (1970) This was in 1859.

2. Bulaway Sketch, 1895. Quoted in Cairns, H.A. "Prelude to Imperialism", London 1965 p.228.

3. Palmer, R. 1977 p.11. He observes that a good many must have set foot on the country, for many died in the 1893 and 1896-97 wars in addition to those who died of malaria in search of gold deep inside the country.



Many settlers therefore moved across the Limpopo on their own. The majority of these were either South African born or had spent some time there. They therefore adhered to the South African land acquisition habits whereby Europeans had virtually a free hand to peg out their own farms. For, had they not been promised as pioneers, 1500 morgens (3175 acres)! Since there was no formalised way of allocating, they were allowed to 'ride them off'.<sup>1</sup> It is notable that those who volunteered to invade Matabeleland in 1893 refused to fight until they had been promised land and mineral concessions and a share of the Ndebele cattle. (Palmer). Clearly therefore, the nature and pattern of European occupation of Southern Rhodesia was determined by commerce, land speculation and the South African tradition of "war and land".

Since the Colonial Office had adopted a policy of non-interference, the company had virtually a free hand. It lacked experienced administrators and so Rhodes was forced to employ:

"the sort of men who preferred speculative fortune hunting ..... and he (Rhodes) had to allow them to make their fortunes if they could."<sup>2</sup>

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1. Ibid p.19.

2. Ranger, T.O. "The Last Word on Rhodes", Past and Present, 28, 1964. 119.

The limitations of funds on the company, made it necessary to use the resources rather than money, as a means of rewarding services (Galbraith 1974). This was doubly beneficial to the company for it also meant the opening up of the country to business, which meant money to its owners. At this point, it was gold which was the prime mover for all the settlers that came up, so gold claims were very highly priced with farming land less priced. The gold rush, unfortunately, was also in the highveld where all the good farming land was. The rush, however, was such that, by the end of September 1890, there were about 300 prospectors between Hartley and Mazoe Valley, but by February 1891, 7000 claims had been marked off. Colquhoun (1893) wrote that many of the prospectors were ill-equipped with clothing, food and medicines so that the severity of the rainy season of that year led to the death, from malaria, of many of them. The problem of health and the environment featured very early in the country's colonisation hence its influence on the process of consolidation of colonial rule.

The brief account demonstrates that there was no adherence to any land agreements either for prospecting or farming. Earlier attempts to have the Crown acquire these agreements so as to protect the Africans from the Company and the settlers, were turned down by the Crown. It is in this vacuum that Lobengula granted a land concession to Lippert in 1891; deliberately attempting to set the latter against Rhodes. This concession granted:

"the sole and inclusive right, power and privelege for the full term of 100 years ....."

to the grantee! Although Rhodes later bought this concession, it remained the first source of major conflict with the African population. As we viewed in sections above, Lobengula himself did not own the country he granted away, nor did he have the right under Ndebele customary law (without going to Mashonaland), to sign the land away! Rhodes knew this, but it was convenient for him to use the 'legal' authority on the Shona who had too many independent chiefs, difficult to track down and obtain an agreement from. The impression one got was that the whole country except the Goldbelt on which there were claims, was up for grabbing!

Palmer writes that even the company's first administrator Archibald Colquhon, felt:

"an utter distaste for the atmosphere of mining, speculation and company promoting, which pervaded the country".

The settlers liked company administrators like Star Jameson who allowed them the right to peg farms where they pleased.<sup>1</sup> Among the early land-grabbers were

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1. Tredgold, R.C. "The Rhodesia that was My Life", London 1968. He wrote that Jameson was, "admirably fitted for the period in which rough justice was appropriate". p.36.



quasi-aristocrats, companies formed in London, fortune-hunters and missionaries. Jameson is said to have induced, through lavish land grants and looted cattle, quasi-aristocrats:

"to come to Rhodesia and advertise<sup>1</sup> the country to their well-connected friends".

By 1896, the total nominal capital of such companies was £20 million and by 1899, of the estimated 15.8 m. acres, alienated to Europeans, 9.3 m. belonged to such syndicates (Phimister). Absentee landlordism had thus firmly established itself in Southern Rhodesia, a sign of falling confidence in mining by the lone prospectors and the company.

The missionaries, who came with a bible in one hand and a gun in the other, also played a big part in the land problem of Southern Rhodesia. Palmer observes that they helped themselves liberally to land so that by the turn of the century, they had acquired a third of a million acres with catholics taking nearly half of it.<sup>2</sup> From the very beginning, J.S. Moffat believed:

"there is ample room for myriads of white people in<sup>3</sup> this country without displacing a single native."

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1. Palmer, R. p.36.

2. Ibid p.36

3. Quoted in Moffat's diary, 1891. (Palmer 1977)



Bishop Knight-Bruce on the other hand believed that:

"the Mashona only occupy a small part of the country, and land which they have never occupied may with justice be said not to belong to them."

Regarding their own holdings, the missionaries claimed they were intended as native reserves in case they (the Africans) were squeezed off their lands; and yet ironically the missionary farms were adjacent to Native Reserves thereby effectively squeezing them out! The Methodist John White in 1911 set out clearly their intention:

"It is my experience that on the farms that we own, we secure an influence over the people we cannot get on the Reserves. They contribute much more generously<sup>1</sup> to the work when living on Mission lands."

Whereas the settlers grabbed the land forcefully and brutally, the missionaries were more subtle about it, but; the net effect was the same - they both grabbed the land from the people and made them work on it for their own benefit.

Such was the ferocity of the scramble that land on the highveld running from Bulawayo through Hartley to Salisbury and to the Eastern highlands was all pegged.

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1. Methodist Missionary Society Archives, 1911.

As for the Matabele highveld, victory in 1893 by the settlers meant they were each granted 6350 acres and within a short space of time,

"the whole of their most<sub>1</sub> valued region ceased to be their patrimony".

This included expropriation of villages within pegged farms! Rhodes, himself, had to intervene and stipulate that the company should endeavour to obtain 9d per acre in Mashonaland! This was hoped to limit the size of the farms purchased.

What conclusions does one draw regarding the settlement pattern and the impact it had on the African indigenous population? Is it possible to discern factors which are likely to persist and cause problems in terms of future policy or influence formulation of future policy?

Mabogunje (1980) refers to this period as one of undermining, which led to subjugation which:

"... effectively removed the independence with which the African trader related to his European counterpart up to then, and left him powerless<sub>2</sub> to resist blatant exploitation and depredation."

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1. Palmer p.38.

2. Mabogunje, A.L. "The Development Process: A Spatial Perspective". Hutchinson University Library for Africa. 1980 p.47.

He quotes Brunschwig as stating that:

"Black Africa was shaken and changed, just as Europe had been by the coming of the inventions .....",

by this undermining.

A.K.H. Weinrich writes on traditional life pattern that,

"The traditional village consisted of an extended family, usually a group of brothers and their dependants, and the chieftain was a village writ large: ideally all men are related by unilineal descent to each other and to their chief. Consequently, the closer men lived to each other, the closer were their kinship ties.. In the economic sphere, neighbours could be relied upon to join work parties whenever labour requirements exceeded the available family labour because people were not only neighbours to each other, but also kinsmen."<sup>1</sup>

The larger number of Europeans who descended on the 'country in the 1890's and their view of land, disrupted the above social formation. This sudden arrival of foreigners, so unlike the foreigners they were used to trading with, who were searching for gold without any form of control, placed great stress on the indigenous population. The psychological impact of occupation, especially on the highveld and in the areas of the goldbelt where the Africans were

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1. Weinrich, A.K.H. "African Farmers in Rhodesia: Old and New Peasant Communities in Karangaland",



dislodged, was unparalleled even in Kenya. The population was thrown into disarray and could not quickly regroup to resist the onslaught. In Matabeleland the 1893 war gave the whites a feeling of conquest and a right of occupation. Since they were the victors they had justification to dominate the vanquished - a hegemonic tendency soon put into wider practice by the occupation of all highveld lands around Bulawayo and the demarcation of Gwaai and Shangani as reserves for the Ndebele, which were completely unsuitable.

It is therefore clear that in the case of Rhodesia, the settlers 'pacified' it rather than the Administrators. The B.S.A. Company, a commercial venture, opened the country since the Colonial Office was hesitant because of logistical and political problems which prevailed then. Kay observes that:

"Commerce led, rather than followed the flag".

This was a phenomenon not experienced anywhere else before. From the outset therefore, the pattern in Rhodesia was different from elsewhere in Africa. The gradualism experienced in Malawi and Zambia was not experienced here and so was the approach to the issue of land. To the whites, as we observed above, there was a lot of free land to 'own'. Beach (1971) points out that:



"a chiefdom might not occupy all its land, but it would know its frontiers and it would be most sensitive to any invasion by strangers."

When the Europeans chose to disregard these factors and actually staked claims of ownership of the land, much more than was reasonable for their individual requirements, they sowed the seeds of deep seated conflict. These deep seated differences in conception were to be the flash-point of confrontation before the decade was over and in the second half of the twentieth century.

The motives for the push into Southern Rhodesia need to be restated to bring out two features of importance in later discussions. It was because of the need to guarantee British Supremacy in South Africa that the search for a 'Second Rand' was launched. It was therefore the political drive to secure British rule that led to the exploitation of mineral wealth initially. The indigenous population was not the threat, it was the Transvaal Afrikaner who was feared. In a bid to fulfill political ambitions Cecil Rhodes and his Company however got men who had their own motives. To these it was the riches the country offered that was the pull. Land was valued for its speculative value in terms of yielding gold. There was however another group of settlers who increased over the years who had a different motive. These were coming to make Rhodesia their home. Having

failed to stake land claims 'down south', they were going to find large farms for themselves, their children and their children's children. These were the Afrikaaner stock. All the groups with their different motivations however, attacked and interfered with the African way of life in a way that undermined his social and psychological stability.

Soon these foreign whites made it impossible for the Africans to practice shifting cultivation and so, after some years the constantly ploughed plots got eroded and did not yield enough food. Soon the settlers wanted labour to work in the mines and to drive their wagons. The African people were not used to working for wages because they did not need them. So the settlers started forcing people to go to work. One pioneer wrote:

"we have great trouble getting native labour up here, the only way we can do it is to go and catch<sub>1</sub> them at dawn and compel them to work".

This amounted to enslavement, so people started to flee their homes thereby disrupting seriously village production and village life. The need to obtain labour led to the introduction of hut tax, which it

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1. Quoted in Mackenzie, J.M. "African Labour in the Chartered Company Period", Rhodesian History, I, 1970.

was hoped,

"would furnish an incentive to labour".  
(Palmer p.43)

The process of domination was taking a firm grip.

The imposition of all these measures brought hardship to the people, but forced labour and hut tax were the last straw, as far as the Shona were concerned. This was an act completely intolerable to the Shona, who had not ceded any authority to the company. The British Government pointed out that this tax amounted to a:

"charge .... for the occupation of their own lands"

on the natives by the company. The process of antagonising the natives had reached a head. It was time to say 'enough is enough'. So, the outcome of the accumulation of the European settlers' activities against a peaceful people were the Chimurenga Wars of 1896-7, which was a war of resistance to a form of domination and subjugation which had reached an intolerable point. This ironically also drew in the British Government's direct intervention to 'suppress the rebels'. This act of naked aggression fully portrays how imperialism established its hold. Now it was going to systematically oversee the administration of the colony, which in short meant



creating the right conditions for capitalist expansion.

It is seen above that in the end Southern Rhodesia came under the colonial fold like all the others although the pattern of settlement inside was distinct in many forms. This background chapter identifies very important features in the formation of the Rhodesian state whose relevance becomes more pronounced in the discussions to come. Since it ended up a colony like many others, in what framework can one seek to understand the path of events which occurred up to the present situation? The discussion in Chapter II seeks to set out the conceptual framework within which events that occurred in Rhodesia can be understood as part of a universal pattern. It is by putting the general trends within a framework that the particular concrete situation can be studied and ways of resolving problems therein worked out. This then, as a follow-up, becomes the subject of concern for Chapter III which examines the particular pattern of events after the turning point of the Chimurenga Wars. The direct outcome of the Chimurenga Wars was to catapult Southern Rhodesia from the pre-colonial state we viewed at the beginning, to a colonial state firmly on the road to capitalist development or within the fold of experiencing capital penetration in 'a backward nation'.



## CHAPTER II

## DEVELOPMENT, UNDERDEVELOPMENT AND HEALTH

Chapter I, examined the historical background of Zimbabwe through a chronological account of events considered to have made landmarks within that state. In this chapter, it is intended to examine the various issues surrounding development and underdevelopment of Third World Countries (UDC's) in an attempt to lay the groundwork for focussing Zimbabwe's place in the international perspective. It is also the intention to put across the thesis that health can be a 'potent lever' for, if not an 'entry-point to', development. The first step would require venturing a definition of development. There is no minimising the difficulty of such a task as can be seen from the amount of literature on the subject. No pretence at being authoritative about this complex topic is made, the intention being to extract those important aspects in the debates which it would be extremely difficult to proceed without examining.

### The Contemporary World View

The one feature which characterises the UDCs is the prevalence of the five giants noted in the Beveridge Report 1942 (it laid the foundation of the Welfare State in Britain), which are: want, idleness, ignorance, squalor and disease. It is notable that these constitute poverty and ill-health. It is from this realisation that health, in its broader perspective, was brought into the problem of development. This awareness, a post second world war

phenomenon, led the United Nations (UN) to inaugurate 1960-1970 the first Development Decade. Now we are moving into the third decade 1980-1990, has there been any significant change in the situation of the UDCs?

Although the use of an average for the UDCs as a whole may not be meaningful, the rate of the per capita Gross Domestic Product (GDP) between 1954 and 1966 was 1.9 per cent for the UDCs as against 3.2 per cent in the developed or advanced Western countries (Paul Bairach). The gap between the two groups of countries seems to have been growing over the centuries from a ratio of 1:7:1 around 1770 to a ratio of 3:1 around 1870 and of 10:1 around 1970! By the year 2000, it might reach 13:1! With all the advances in science and modern communications what could be the explanation of these grave and worsening disparities between countries? What is their relevance to health? Why are they of interest to a study of Zimbabwe especially one which intends to concentrate on planning of health for development?

These questions I will attempt to answer in the following discussion in the order in which they are posed. During the course of the discussion, further sub-questions will be raised to enable me to examine the issues involved more extensively.

Rhys Jenkin (1977) observes that the granting of independence to many former colonies and the increasing tendency of these states to turn socialist, has forced the



former imperialist countries to seek new rhetoric to entice those independent states to remain in their sphere of influence. Of course, the capitalist nations are aware of the hardening attitudes in these countries, towards the more conventional modes by which the Western nations maintained influence and control, ie through aid and assistance. It has therefore become necessary to coin new terminology with some semblance of parity in dealings, hence, 'North-South dialogue', and 'New International Economic Order', and Global Strategy to solve the world's economic problems'. This centres around the need to improve the terms of trade between the rich North and the poor South. The UDCs realise, and are voicing, the unfairness of the terms of international trade, which price their exports of primary products very low and finished products from the North very high.<sup>1</sup> Further it makes them

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1. BBC2 Documentary, 30.12.81: "Global Report: An Alternative Account of 1981". The commentary noted that the figures which were before the twenty-two negotiators representing the Advanced Countries (the North) and the Underdeveloped Countries (UDCs) (the South) showed the following disparities: In 1981, US\$13 billion was spent on aid to the UDCs, a sum less in real terms than that given twenty years ago; US\$35 billion was granted in Commercial loans in 1981 and with interest, it will be repaid at almost twice the amount at US\$60 billion; US\$145 billion worth of raw materials exported to the developed North would multiply eight times in value in these countries through material processing before the finished products find their way back to the UDCs as hardware. Two-thirds of the income in the UDCs, amounting to US\$160 billion in hard currency, was paid to the North to purchase hardware for the UDCs and for social and economic development aid schemes there. The unfavourable nature of the transactions to the UDCs efforts to develop is self-evident hence the persistant increase in National Debts commitment in these countries. The developed North ascribes these disparities to the mechanisms of the /...

dependent and subordinate to the latter who control the world pricing mechanisms.

Concern over the lot of the underdeveloped countries, (UDCs) where almost 80% of the population will be living by the turn of the century<sup>1</sup>, has been shown, to varying degrees throughout the history of the world economy as depending on the situation in the capitalist world economies. Between 1960 and 1972, the member states of the Organisation for Economic cooperation and Development (OECD) increased their real gross national product by an average of 5.4% per year.<sup>2</sup> It is these same states that boast the biggest per capita annual incomes, a greater life expectancy at birth and low population growth rates.

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...../'free-market forces' which inevitably work in the North's favour. The North continues to pursue a non-interventionist stance to the market mechanisms. By contrast, the UDCs called for active intervention of the North to regulate market forces and thereby uphold their moral obligation to the poor UDCs. It was precisely on this point that the conference failed in extracting a firm commitment from the North's representative governments (the USA and the UK) towards fixing prices for the benefit of the poor UDCs and instead agreed on a vague statement to continue to pursue the issue at the United Nations.

1. World Health Forum, 3(2): 1981, p.264-280, "In Focus: The World's Main Health Problems", WHO Sixth Report On The World Health Situation.
2. WHO, Public Health Papers, No.69, p.13: "Poverty, Development and Health Policy". These countries constitute all the developed capitalist economies.



"In 1972 the industrial market economy countries, with only 17 per cent of the world population, accounted for 67 per cent of total world output... . At the other extreme, 26 per cent of the world's population lived in countries whose total output accounted for under 3% of the world total ..... The 17 per cent of the world's population living in the richest countries .... produce<sub>1</sub> and consume 40 to 50 per cent of world output."

The World Bank<sup>2</sup> estimates that nearly 800 million people, ie about 40% of the developing countries population, are living in absolute poverty. The majority of them are noted to be in rural areas, the greatest concentration being in South Asia and Indonesia, with Sub-Saharan Africa having a high proportion of its smaller population in a similar state. High perinatal and maternal mortality rates, high infant mortality rates and low life expectancy,

"..... (are) becoming exclusively a problem of the poverty complex, they are highest among the poor, in particular high parity, very young or very old mothers, as a result of gestation and childbearing intervals that are shorter<sub>3</sub> and low general health and nutritional levels".

The existence of a close correlation between the above and economic indicators, like per capita GNP, makes it important that the pressure for a fairer world economic system be sustained. The relevance of economic development to health requires international recognition.

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1. ILO, 1976 p.29 "Employment, Growth and Basic Needs", Geneva.
  2. World Bank Report, 1978 p.26: "World Development Report" Oxford University Press.
  3. The Sunday Times, 24.10.81 "Cancun, The Only Missing Word is Commitment".

The latest of the attempts to bring about such a fairer world, with a better deal for the UDCs, was as a result of the report of the Independent Commission on International Development Issues, more popularly known as the Brandt Commission. This Commission was a brainchild of World Bank President, Mr Robert MacNamara, though ultimately it emerged as a self-appointed body. It came about because, the North-South dialogue, initiated after the declaration of the New International Economic Order, (NIEO) was deadlocked. Why was this so and was the new attempt any better fancied to succeed? The earlier attempt was seen (by the World Bank and in the Advanced countries) as a repudiation of the strategies and "trickle-down" theories then dominant in those institutions with regard to relations with the UDCs. Clearly there was something in the NIEO approach which challenged the 'status quo' of the relationship between advanced and underdeveloped countries. This makes the basis of the Brandt Commission report suspect. Nevertheless, it underlied the interdependent nature of the world today, (an already recognised view) and stressed that the world's ills require:

"truly global solutions beyond the reach of any single country or group of countries".

It called for cooperation in solving problems and its ideological plea was based on "mutual interests" between the North and South.<sup>1</sup>

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1. Ibid.



Following upon this, the Cancun Conference from the 20th to 23rd October 1981, between representatives of the North and those of the South, was held in Mexico. There were twenty-two nations who met and discussed. The concern of the Western capitalist economies was demonstrated by the personal attendance of the President of the USA and the Prime Minister of the United Kingdom - Mr R Reagan and Mrs M Thatcher - all great believers in a free market economy. It was the British Foreign Secretary, Lord Carrington, who summed up the British view to the discussions,

"we are one world and need each other"

"it is the right thing for Britain".<sup>1</sup>

There is no disputing the accuracy of the second remark which probably applies, at this point in time, to all advanced countries. Should this rhetoric be viewed as a sign of repentance for all the centuries of profit expropriation and labour exploitation in the UDCs? Is it rather covering up for their institutions like IMF and World Bank who have openly been hostile to Socialist oriented UDCs and well disposed to corrupt but Western leaning governments? The best illustration of how these institutions act on behalf of world capital interests in the context of the aforementioned is the case of Tanzania and Zaire. The one despite its popular government

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1. World Bank, 1978 p.269: "World Development Report"  
Oxford University Press

and policies at home was refused loan funds and the latter, with its characteristic corruption, inefficiency and unpopularity, was granted the funds under cosmetic conditions. The direct political posturing of these UN agencies raised questions among some UDCs which were confirmed by the lack of commitment at Cancun by the advanced nations; this earned it the label of "Cancun, the Charade".<sup>1</sup>

What then are we seeing at the global level - in terms of approaches to the issues which have governed international relations? Is it that the UDCs have now awakened and are now taking a determined stand against the developed nations? The state of the Western economies, with unemployment running high in the UK and in the USA, is such as to lead one to deduct that these countries must be frantically searching for solutions albeit temporary ones. The present depression is driving the capitalists to making some obscure concessions in a bid to buy time and find new ways of exploiting the UDCs. The character of capital keeps changing to cope with new circumstances, capital's internal dynamic keeps transforming it thereby enabling it to survive, even thrive, under changing conditions, so long as surplus value can be made. The depression creates all the conditions for the uprising

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1. Chakravarthi, R. "Will the Brandt Report Kill PHC?" Inter Press Service, Third World News Agency; World Health Forum 3(2), 1981, p.281.



of the masses. How then has capital and the bourgeoisie managed to survive in the midst of the discontented millions within their countries and in the exploited UDCs?

The experience in Britain in the late nineteenth and early twentieth century shows that, to avert confrontation as occurred in France during the revolution, arising from the workers, the British ruling class made some concessions. In this period, some welfare reforms were introduced and later at the end of the Second World War, a welfare state as promised, was introduced.<sup>1</sup> The critical question now is whether there is still something substantial to offer the clamouring, striking workers without reducing the wealth of the ruling class? The alternative sources of wealth, to pass on to the workers within the centre, are diminished, therefore everything will be tried on the UDCs, the traditional sources of surplus value, to dig even deeper to provide for the workers at the centre. Because most, if not all the former colonies are now independent and most have adopted a socialist orientation in a show of distaste to the former

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1. Maurice, B. "The Coming of the Welfare State". He postulated here that it was out of economic necessity rather than political conviction that the Conservative Government (1911) under Lloyd George, in the first instance, and the Labour Government (1945) finally, made the concessions that led to the introduction of the Welfare State. Of course, the growing strength of the workers through the Trade Union organisation and other factors, also contributed, but they were not the determining factor.

colonising power, the emergence of a new rhetoric and forging fresh links have been fiercely embarked upon. In the face of all this, the gap between the developed and the UDC's has continued to widen, as we saw in the opening paragraphs. This suggests the predominance of a deeper seated force built into the process by which the developed countries got to where they are and how they related and continue to relate with the underdeveloped countries.

In order to find answers to these complex questions, an understanding of the issues in development and under-development is required. In the final analysis, a global view of the role of health in development will be taken. Illuminating but brief analyses of theories advanced in an attempt to understand the processes going on between UDCs and developed countries and inside UDCs will be made. In the context of these analyses, the situation of Zimbabwe over the years will be viewed in the following chapter.

#### DEFINING DEVELOPMENT

The glaring differences observed in the opening paragraphs between the developed North and the under-developed South have led to the search for the real meaning of development. The nearest definition of this complex process which involves the interaction of political, economic, social, educational and other factors which do not necessarily evolve smoothly is given by C.T. Kuriel in "Poverty and



Development". He quotes the Papal Encyclical entitled: "On the Development of Peoples", that:

"Development cannot be limited to mere economic growth. In order to be authentic, it must be complete, integral: that is, it has to promote the good of every man and of the whole man. We do not believe in separating the economic from the human, nor development from the civilisation in which it exists. What we hold important is man, each man and each group of men, and we even include the whole humanity."

A clear move from the economic model hitherto prevalent, this new concept of development emphasises the full integration of human activity as the only sure way of guaranteeing growth to human fulness. This concept is presented in terms of fundamental humanistic values, the core being - the de-alienation of man vis-a-vis the material forces of production and society. Man is viewed as the end product of development and therefore it must be judged in terms of what it does to him. It becomes the process by which one's personality is enhanced individually and as a member of society. In it economic and non-economic elements interact organically with each other. It has been often viewed as a multi-variable-quantitative and qualitative change, which may not be measurable cardinally and requires the use of value judgement.

Another theological document claims that:

"Development is the liberation of people from the various forces that conflict and stifle their human existence so that they are free to grow to fullness. Development provides opportunity for a spontaneous

creativity assuring everyone access to all necessities of life including knowledge and culture".

This latter view observes that to engender development, there is need to bring both growth and social justice together in programmes of action. This clearly leads development into an all-comprehensive sociological problem which must of necessity address itself to power relations within the society. Conflict resolution ought therefore to be built into any developmental decision-making process.

Although no model can be universally applicable 'in toto', Diagram 2:1 shows the elements that make the build-up to real development. It starts off by recognising the basis of true human development -

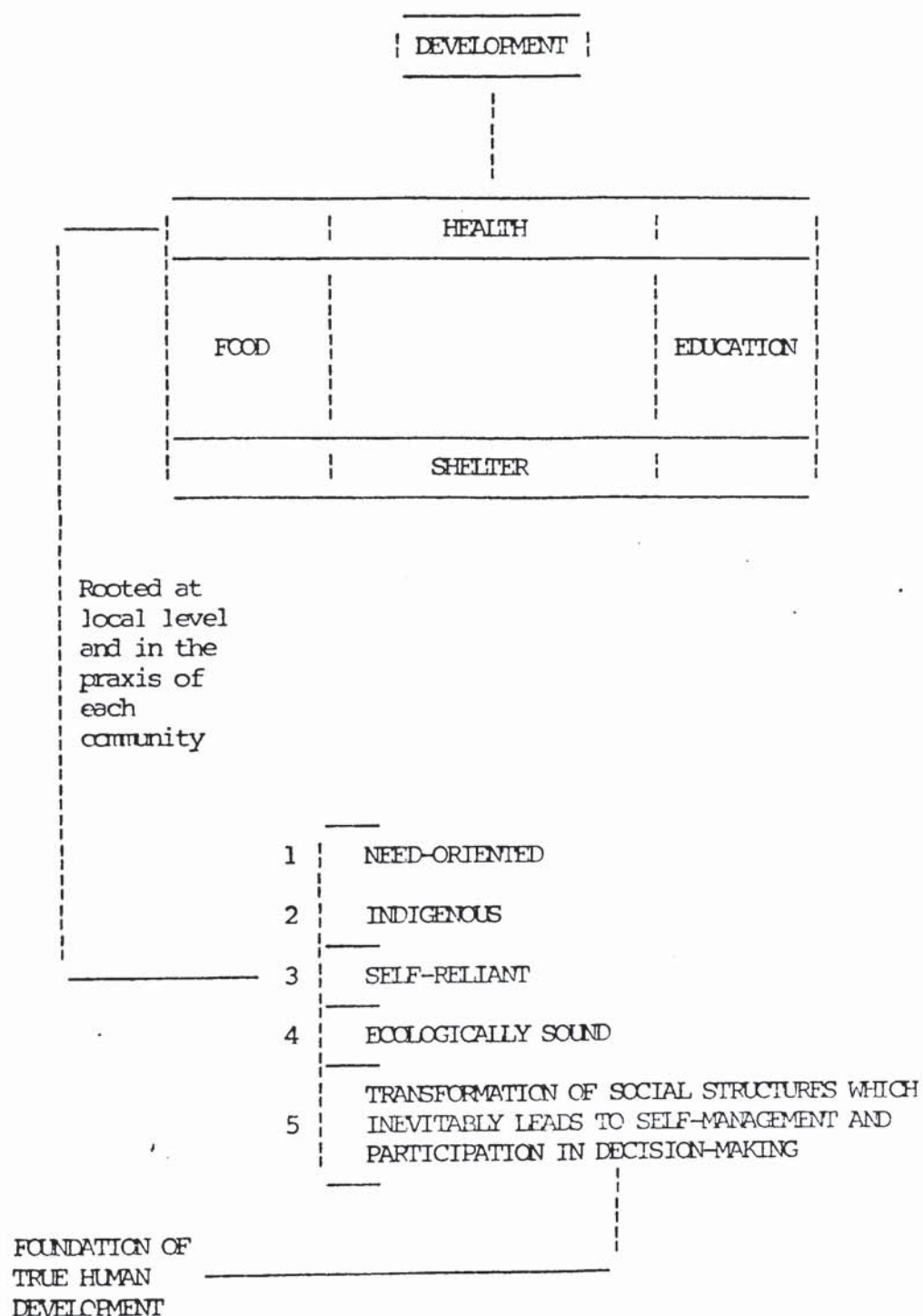
"the liberation of people .... so they are free to grow to fullness". (Kuriel)

This is brought about by a sound ideology and clear political guidance through a well functioning party organisation. This in turn calls for a real transformation of social structures which stifle human psychological and attitudinal maturation, to create new ones which lead to self-management and participation in social and productive sector decision-making processes. This is the critical foundation that nations should strive to lay. This ensures that the impact of real development is felt, if it lives up to its aim to "open our people to opportunities for a



DIAGRAM 2.1:

ELEMENTS OF DEVELOPMENT<sup>50</sup> -



BUILD UP TO DEVELOPMENT MUST START FROM THE HUMAN BASE  
NOT BE IMPOSED ON THE HUMAN ELEMENT

(Adopted from 'Development Dialogue',

"Towards a Theory of Rural Development", 1977)

richer, more varied life";<sup>1</sup> by the bottom 40% of the population in dire poverty! These constitute the main focus, hence the 'bottom-up' progression of the model.

Following on the above, it concerns itself with coming to terms with one's environment in order to function fully within it and be able to influence it - hence the need for ecologically sound approaches. Utilisation of appropriate technology through self-reliance schemes is also advocated, so as to reduce the country's dependence on foreign industrialised-nations-produced high-technology equipment, a practice which generates adverse controls by the latter which we examine below. Community transformation cannot come about from outside, if it is real and lasting it has to originate from in-within the community, geared to the community's needs and available resources. Externally imposed change has been the cause of much suffering in Third World countries as we shall see later. It tends to be extroverted and perverse, serving the interests of those external countries and perpetuating existing internal inequalities through alliances with the powerful nations.

What we observed above must be rooted at the local level and in the praxis of each community that has made a decision to develop and advance to fullness. Human needs are however boundless, but available resources to meet

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1. World Bank, (1978)

them are only finite, hence the need to prioritise them. Four basic human priority needs are identified as: FOOD, SHELTER, HEALTH and EDUCATION. ("Development Dialogue" DAG Hammersjold Foundation (1978) I p.6). Without these, it is not possible to sustain a normal life and vice versa, by promoting these you promote development. One can note from the operational definition and emphasis of development that it aims within countries to: stamp out poverty, hunger, misery, want, ignorance and idleness, all noticeable by-products of under-development. The multi-disciplinary nature of the problem it attempts to tackle, the political content of the aspects and the socio-economic overtones, are all too clear. In the face of this clear view of the demands it imposes, the United Nations in its Second Development Decade proposal (1970-1980) stated:

"Development, far more than being measured by increased productive capacity, requires major transformation in social and economic structures - while high rates of growth output and income are required if mass poverty is to be eliminated, opportunities have to be generated and social measures financed, the process of development has itself to be reviewed in terms of fundamental structural changes!" (Kuriel p.48)

Instead of merely concentrating on the inadequacy of redistribution (ie allocative efficiency) within and between countries, this proposal draws attention to the need to increase production - (ie productive efficiency) and generate fairness in exchange within and between countries. The power of the external political, economic and social forces on UDCs, which is not given much



prominence in the above view of development and the development process, is considerable. The major political and economic structural transformations required in them before they can develop are considerable because they are at the very basis of international relations. Intra-country and inter-country tinkering with trade relations and preferential exchange in the UDCs only makes marginal differences. What is required is; a deeper understanding of the forces that govern international economic relations and how they came about and an undertaking coupled with serious action to redress the unfairness of the terms of trade and exchange in favour of the UDCs.

By seeking to understand the material base of UDC problems, we gain an understanding of the political and social structures set-up to sustain it. The latter are often determined by the former and are always influenced by changes in it. Through understanding these baseline interrelations the first step towards instituting developmental processes will have been taken. The discussion on underdevelopment and the elucidation of a number of theories on underdevelopment and schools of thought on the phenomena, is an attempt at offering a systematic methodology of analysing the problems. To be understood, a general framework has to exist within which a particular country's experiences fit. Because experiences are best expressed through an historical account, a similar appraisal is made of the main



frameworks of analyses. The idea is to highlight the best aspects of each framework of analysis by applying each individually to the general, in the first instance and to the particular, throughout the study.

To summarise, the pattern of development of a country, and the fulfilment of that level of development which is considered adequate is dependent on internal and external structures, endogenous and exogenous factors, which interact intra-nationally and inter-nationally, on themselves and with each other; on an existing material base - with the ultimate objective of improving quantitatively and qualitatively, man's life within a nation. The following section will examine the context within which the external relations can be understood. It considers frameworks of analyses which have some universal application. In the following chapters, it is intended to examine the internal and endogenous factors which may be important in the development process, and the issues that arise from attempting to situate these factors to specific, concrete circumstances of Zimbabwe.

#### UNDERSTANDING UNDERDEVELOPMENT

##### The Classical, Neo-classical and Economic Views

A number of theories have been advanced in an attempt to define the origins and form of under development. The earliest of these was the Orthodoxy theory (classical)

of economic development which viewed under-development in quantitative terms as indicated by low per-capita National Income or other indicators like cars, doctors per head of population.<sup>1</sup> It views under-development as an original state akin to traditional society. W.W. Rostow identifies five stages of growth<sup>2</sup> and asserts that all countries were once under-developed! This school of thought sees development and under-development as 'two points along a continuum' and therefore addressed itself to the problem of how to wrest a country out of this state into one resembling advanced capitalist countries - a catching-up process.

The above fails to recognise that, in developed countries Capitalism emerged out of feudalism, whereas in the under-developed countries, the now seemingly universal capitalist relations of production, have been introduced from outside and co-exist with pre-capitalist modes of production.

The neo-classical view on its part sought explanations for the conditions of under-development from economic considerations which were based on experience of the

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1. Jenkin, R. (1977) "Underdevelopment", Reprinted from, "Economics. An Anti-Text". Green, F. and Nove, P. Macmillan Press Ltd.
  2. Rostow, W.W. "The Stages of Economic Growth", Cambridge University Press, (1962)

developed countries. It therefore identified lack of capital; because of nil industrialisation within the underdeveloped countries; the tendency of rapid population growth, which absorbs limited increases in outputs; problems of unemployment and under-employment; as major factors leading to the state of underdevelopment. Rhys Jenkin (1977)<sup>1</sup> further quotes Samuelson's assertion that:

"poor countries typically have been poorly endowed by nature, and such land and minerals as they do possess must be divided among dense populations",

- as being empirically invalid. The existence of abundant mineral wealth in Zaire, Zambia, Angola and Zimbabwe support his argument and furthermore, the case of Japan shows that abundant mineral resources are neither a necessity nor a sufficient condition.

A major part of neo-classical theory is concerned with allocative efficiency while it can be argued that, the problems of underdeveloped countries are those of mobilising rather than allocating resources. It emphasises harmony rather than the conflict imposed by the international capitalist economic relations and by so doing exonerates developed countries for having created underdevelopment. This view provides the basis for

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1. Jenkin, R. (1977) "Under-development", Development Studies Reprint, No.41 from "Economics: An Anti-Text", Green, F. and Neve, P. Ed. Macmillan Press Ltd.



neo-colonial relationships through aid and preferential trading schemes. R. Jenkin (1977) rejects it and concludes that: (p.139)

"the expansion of capitalism has both had a direct impact on the economies of Latin America, Asia and Africa in the past, changing their internal structure, and has changed the external conditions which face these countries".

Clearly this economic approach to under-developed countries led to the growth of 'metropolis-satellite' relations, paternalistic attitudes, indiscriminate imposition of laws, customs and ways of life alien to the particular country, with no regard to existing cultures-structures, institutions and the social state. This approach, which dominated thinking in colonialist countries, led to massive exploitation of the UDCs and made them subservient to forces outside and beyond their control. The process of development of capitalism in the backward nations had begun in earnest and required to be understood if it was to be successfully fought.

#### Marxist Theory of Imperialism and subsequent analyses:

Underdevelopment, referred to as, 'Capitalist development in backward nations', is discussed in the context of the debate on imperialism in Marxist analysis. Imperialism at one level denotes:

"a relationship of a hegemonic state to people or nations under its control" (Lichtheim, 1971, p.10)

Its essence here is domination and subordination through colonialism or through a complex and diffuse system of international relations of dependency which distorts the development of nations. Of greater interest is how these relations of domination and subjection are situated in the context in which they develop. (Palma (1978) p.882)

Marxist analysis of imperialism and its interpretation centres on the material base of production but without rejecting the existence of relations with the super-structure (ie political, ideological, economic or cultural factors). The nature of the relations between the two is not necessarily complete - ie the one sometimes 'determines' 'conditions' or 'corresponds' to the other. Agreement however exists on that changes in the base are necessary, but not sufficient, for changes in the superstructure. This is not to say that man is simply a product of material conditions but merely to admit the importance of his interaction with nature.

G. Palma observes that the nucleus of Marx's analysis is the labour theory of value; which states that the capitalist mode of production is governed by the drive to extract surplus value from a class of wage labourers, realise the surplus by finding a market for the commodities in which it is embodied, and turning the surplus into investment in new means of production to maintain and expand the process.

Sutcliffe (1972,p.172) distinguished in the theory of

imperialism three distinct phases in the relations between capitalism and the peripheral countries: the one involves plunder and exports of capitalist manufacture to the periphery. The second (uppermost in Lenin's writing) involves export of capital, competition for raw materials and growth of monopoly and the last, involves post-colonial dependency of peripheral countries with foreign capital repatriating profits, adverse terms of trade all combining to distort or halt economic development and industrialisation.

In each of the noted phases the peripheral areas furnished the needs of advanced capitalist nations. G. Palma (1978) in the discussion on 'Marxist theory of capitalism', postulates that to each of the phases noted above, there corresponds,

"a particular analysis of the development of capitalism in backward nations".

Marx and Engels' analyses demonstrate capitalism to be a historically progressive system which will be transmitted from advanced countries, (through colonialism, free trade, etc) to backward nations, by a continual process of destruction and replacement of precapitalist structures. A result of this process would be new capitalist societies whose development in the post colonial period would be similar to that of the advanced countries. Inevitably, this would be followed by the development of contradictions inherent in the capitalist system.



The second approach to the development of capitalism was by the so-called 'classics of imperialism'. This made a distinction between two major historical stages the first of which analysed capitalist development in colonies as historically progressive, but limited by the new imperatives of the advanced economies in their monopoly phase. These imperatives succeed in restricting modern industrialisation in colonies, according to Palma, thereby perpetuating links which could however be broken at independence and industrialisation embarked on. On the basis of this view, "industrialisation would take on a similar character to that of the advanced nations" (p.886) and consequently, would have political and economic difficulties and contradictions with the national bourgeoisie developing their own revolution and undertaking late industrialisation. This analysis therefore saw developed and underdeveloped countries as being at different points along the same continuum!

The third approach, whose main proponent was Baran (1957) in "The Political Economy of Growth", argues that no Third World (UDC) country can now expect:

"to break out of economic dependency and advance to an economic position beside the major industrial powers".

The importance of this contribution was its demonstration of the extent to which capitalism remains progressive in the modern world and "the economic background to political

action". The dependency school emerges from this approach although this is a later development related to the Latin American political and economic scene (Palma 1978).

Marx's approach, though scattered throughout his works is still discernible. He makes the distinction between 'the subjective motivations for capitalist expansion and its objective historical results'. (Palma 1978) He condemns the expansion as,

"the most brutalizing and dehumanizing that history has ever known",

and at the same time argues that it is necessary for the backward societies if they are to develop. He asserts that:

"only capitalism ... can provide the necessary economic and technological infrastructure which enable society to allow for the the free development of every member ... and (it) .. can only develop in them through its penetration and imposition from abroad".

It is in this context that Marx wrote in the preface to the first edition of 'Capital' (1867 p.xiv) that:

"the backward country suffers not only from the development of capitalist production, but also, from the incompleteness of that development".  
(Quoted in Palma p.887).

It can be viewed from the above that Marx's analysis dealt

with the necessity for capitalism (both politically and economically) as a step towards higher forms of productive forces; and its possibility and viability. He concentrated on the necessity, whereas present analyses centre on its feasibility, in the periphery. Until much later in his life, he states:

"that socialism can only be attained through capitalist development ... (in the backward regions) ... by the impact upon them of the Capitalism of Western Europe itself". (Palma 1978).

Marx was overtly hostile to the unchanging nature of production modes in backward nations. He saw this as a drag on the process of history and referred to these modes in derogatory terms as 'nations of peasants'.

Whether endogenous or exogenous in origin, Marx believed that once it has been implanted in a society, capitalism will develop in a certain way. If one of its central characteristics is to develop both objective wealth and poverty, this would exist within each society rather than between societies.<sup>1</sup> This observation raises an important feature of the relativity of poverty and the dangers of making cross national comparisons.

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1. Perhaps it is this universal pattern of capitalist development (which amounts to similar underdevelopment trends within UDCs) that gives validity to the endogenous based solutions proposed under the definition of development and illustrated under diagram 2:1. The adoption of such courses of action by all UDCs individually, effectively dries off, the abundant sources of surplus value per capital which makes it thrive.



As a way of summing-up Marx's view in the preface to Capital (1867), he wrote:

"the country that is more developed industrially only shows to the less developed, the image of its own future".

Kierman (1967 p.183) on analysing the above concluded that Marx was not advocating further spread of Western imperialism, far from it, he was advocating,

" a proliferation of autonomous capitalism".

One can safely observe from the above that the attitude of some dependency writers that capitalist industrialisation in the periphery is no longer feasible goes against the spirit and letter of Marx's writings (Palma 1978). It can also be derived from the quote in "Capital" (1867) that Marx also saw development and underdeveloped as points along a continuum.

The 'Classic writers' on imperialism - Rosa Luxemburg (1913), Bukharin (1915) and Lenin (1916) who based their writing on concrete developments of capitalism, were able to identify the driving forces behind the economic expansion of the advanced capitalist countries in the financial and economic spheres. The financial forces are related to the need to find new investment (since their own economies are incapable of generating these forces at the same rate they generate Capital); while the

productive sphere forces are related to the necessity of ensuring a supply of raw materials and continued market for manufactured goods. The net result is a tendency towards greater integration of the world economy, a considerable degree of capital movement and an international division of labour which restricts growth of backward economies to production of primary products. The labour in these economies is paid very low subsistence level wages because the primary products have to be cheap, despite the fact that;

"they generate economic activity eight times their value in the processing undertaken in the advanced countries" (Quoted in 'Global Report: An Alternative Account of 1981' - see footnote).

The expansion of the world economy leaves the backward economies indebted to the developed nations since they now have a productive structure that produces what they themselves do not want or consume and leads them to consume commodities which they do not produce! This situation results from the unequal exchange on the world market which is outside UDC's control.

The main difference between 'the classic writers on imperialism' and Marx, centres on the fact that the former saw capital's progressiveness in backward nations as the basis of contradictions with advanced countries - ie monopoly capitalism created conflict. This was because once the colonial bonds were broken,

"the incipient national bourgeoisies can proceed with development ... completing the bourgeois revolution and attempting to industrialise".  
(Palma 1978 p.897)

Monopoly capital however tended to continue to flourish thereby frustrating the national bourgeoisie efforts to control the economy. The situation in the history of Southern Rhodesia which culminated in the Unilateral Declaration of Independence (UDI) in 1965 provides a fascinating example of a country which would fit in this framework of analysis. This is the subject of Chapter Three. Marx, who points out that the accompanying problems of inherent contradictions in capital will also be imparted to the backward nation, through the necessary capital penetration, does not see 'capital's progressiveness' as the basis although its existence sharpens the contradictions.

The final phase in the development of Marxist thought on capitalist development in the backward nations was the approach which gave more importance to the role played by the traditional dominant classes of the backward countries. These groups' power was opposed to the transformation of internal structures, from which they derived their dominance and control; by capitalist development and industrialisation. Clearly, alliances between them and imperialism are obvious choices. Degras (1960) argues that:



"When the dominant imperialist power needs social support in the colonies, it makes an alliance first and foremost, with the dominant classes of the old pre-capitalist system ... against the majority of the people".

This final development in Marxist thought analysis sees previous alliances - "the feudal-imperialist-alliances" - between imperialism and traditional elites as limiting progressiveness of capitalism (Palma 1978). The success of industrialisation is seen, in the final analysis, to depend on the incipient national bourgeoisies' ability to develop, in the post colonial phase, political capacity to assert themselves over that alliance.<sup>1</sup> This would include prevention of adoption of liberal political and economic policies sought by the alliance, as happened in Southern Rhodesia when British government efforts were thwarted by UDI. In the case of Latin America, Palma saw this double contradiction of capitalist development as having dominated political and economic analyses up to the 1960's. The case of Africa presents varying features between countries which had a sizeable settler population at independence and those that did not. In the former the perennial nature of the settler group meant that they

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1. The string of legislation introduced from 1923, when responsible government was granted to Southern Rhodesia and more so after UDI (1965), seem to indicate this frantic attempt by the settler national bourgeoisie in Zimbabwe. Indeed they industrialised under their white minority post colonial government, which makes the analysis of what occurred in the case of Zimbabwe fascinating - see Chapter III.

formed part of, if not the only, national bourgeoisie. What happens to the indigenous elite is determined by these settlers who at the same time see this elite group as a challenge. How the settler community relates with the imperialist colonial power and the local representatives of monopoly capital, together with the traditional dominant class, presents an interesting political game which is the subject of subsequent chapters in the case of Zimbabwe.

#### Underdevelopmentalists

The 'theory of underdevelopment' group, (Palma, 1978) is a post World War II development which arose in an attempt to articulate more accurately the international economic relations between the industrialised and the non-industrialised countries. The most extensive studies in this group were made in Latin America and led to the growth of the 'dependency school'. In this study, only a brief look is made at the debate with emphasis being made on its wider implications regarding the nature of international economic relations. The effects of these in UDCs are noted in general terms. It is noticeable, as we observed above (p. ) that these studies concentrated on the feasibility of capitalist development in the peripheral economies, whereas Marxist analyses emphasised its necessity.





Anne Philips<sup>1</sup> sees the fault in these analyses as resting within the development problematic itself. She sees a need to challenge the framework of the analyses in the African context, and even break from the ultimate ideological question, for this may lead to limitations imposed by the problematic, eg that all definitions of development imply capitalism. The under-development proponents, in her opinion therefore, beg the question in so far as they offer justification for socialism, which is focussing on its desirability rather than on the scientific, practical, political issues. In her view, development as a concept cannot be isolated from the structure of social relations with which it forms the mode of production.<sup>2</sup> Although capital is able to push out peasant modes of production, it has a tendency to hold back the production transformation in certain areas thereby distorting development in a perverse way.

The study of the development of Latin American capitalism led to the growth of the theory of dependency; or as Palma puts it, 'the schools of dependency'. He distinguished three approaches; those who reject the possibility of

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1. In Review of African Political Economy, No.8. 1977.

2. Marx, K. (1959) Capital Vol.I, states that feudalism and capitalism are modes of production. Foreign Languages Publishing House, Moscow. Laclau, E. defines mode of production as meaning "an integrated complex of social productive forces and relations linked to a determinate type of ownership of the means of production".



capitalist development in Latin America and only speak of 'development of underdevelopment' or 'the underdevelopment of development'; those who concentrate on obstacles confronting capitalist development; and those who accept the possibility of capitalist development in Latin America but emphasise its subservient role to the centre.

The following discussion proceeds by viewing the approaches in the above order and where applicable, makes references to black African countries.

Baran (1957) threw open the contradictory character of the needs of imperialism, the process of industrialisation and general economic development of backward nations when he affirmed that:

"What is decisive is that economic development in underdeveloped countries is inimical to the dominant interests in the advanced capitalist countries" (p.28).

The emphasis of capitalism to transfer of surplus value from the periphery to the metropole meant, in effect, that capitalism hindered development thereby leading to underdevelopment. It was either that foreign capital expropriated surplus value or the traditional elites spent it on consumer goods. The net result was the same; the resources for investment were lost or reduced, thereby diminishing the multiplier effect, this led to

importation of capital which could lead to economic stagnation. This cycle would be impossible to break through economic methods, the only solution thereby becoming political.

Gunder Frank attempts to develop the thesis that the only political solution is a revolution of an immediate socialist character;

"for, within the context of the capitalist system, there could be no alternative to underdevelopment". (Frank 1967).

He conducts an historical analysis in which he distinguishes three levels; in the first, the areas in the periphery are incorporated into the world economy through colonialism; as a result of the incorporation, they are transformed immediately and necessarily into capitalist economies (he asserts that they are capitalist anyway!) and; finally the integration into the capitalist economy through an interminable metropolis-satellite chain, in which the surplus generated at each stage, is successively drawn off towards the centre. The satellite status seemed to him to generate under-development, therefore he suggests that;

"a weak or lesser degree of metropolis-satellite relations may generate less deep structural development and/or allow<sup>1</sup> for more possibility of local development." Frank 1967.

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1. Frank, A.G. (1967) "Capitalism and Underdevelopment in Latin America", Monthly Review Press, New York.

But since these relations originate externally to the satellite, they can only be weakened externally, thereby confirming that there is no real possibility of sustained development within the system. Capitalist development in the periphery is therefore seen to be infeasible.

Lenneiye<sup>1</sup> observes that,

"the Frankian model of underdevelopment recognised that underdevelopment is not an original state, the developed countries were once undeveloped not underdeveloped."

Here, underdevelopment is the result of the relationship between industrialised and non-industrialised countries, as an essential part of capitalist development. Thus underdevelopment represents the destruction of the socio-economic relations in existence at the periphery, by the centre. Clearly therefore, the continuum concept of development is rejected together with the Marxist observations that developed countries reflect now what underdeveloped ones will be in the future.<sup>2</sup>

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1. Lenneiye, Mungai Nginye: "Health and Rural Development in Kenya: An analysis of Health Services Availability and Utilisation within the Framework of Class Formation in Rural Areas". A Ph.D. Thesis, University of Bradford, 1980.

2. See discussion p.



Lenneiye (1980) concludes that,

"the level of underdevelopment is proportional to the extent to which the satellite is integrated with the metropole".

This view corresponds to that expressed by other writers that development and underdevelopment are opposite faces of the same coin or 'two sides of the same coin'.

(Sunkel 1973a) This conception was applicable beyond international relationships of underdevelopment to include national, regional and local centres in the satellization process within world capitalism. The transfer of surplus value is therefore continued within underdevelop countries through local centres 'plundering locally produced surplus', to benefit owners of capital in the metropolises. This leads to the urban-rural bias whereby the former underdevelops the later. In the process, an indigenous exploiting class grows to join and work with and on behalf of the traditional elite and the metropole.

From the above it becomes clear that Frank rejected the dualist theory which states that UDCs are made of two distinct economic sectors, the one modern and capitalist and the other stagnant and backward providing labour for the former. Lenneiye demonstrates that the dualist theory<sup>1</sup> ignored the importance of peasant accumulation

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1. (See Footnote 1 on following page)

and commercialisation which go hand in hand with proliterianization. Marx did not fare very well on the same score for he referred to backward nations as stagnant and 'nations of peasants'.<sup>2</sup> Frank reckoned that Latin American countries were capitalist since their colonization in the sixteenth century.

The debate Frank's work generated is important because it brought out some of the weaknesses of his model.<sup>3</sup> Laclau (1971) disputes his assertion that Latin America has always been capitalist, and pinpoints Frank's failure to distinguish feudalism from capitalism. Laclau saw the fundamental relationship of capitalism as constituted by:

"the free labourer's sale of his labour power, whose necessary precondition is the loss by the producers of ownership of the means of production". (Quoted in Lenneiye 1980,p.15).

Under these circumstances, capitalism co-exists with semi feudal conditions without constituting

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1. Lewis, W.A. 1959. "Economic Development with Unlimited Supplies of Labour" Manchester School and, 1959 "The Theory of Economic Growth", Allen and Unwin, London. These works supported this dualist theory.
  2. See discussion p.
  3. This part of the analysis of the debate is very relevant for the discussion in the next chapter in Zimbabwe where the indigenous population was forced to supply labour! A later day version of slavery!

dualism<sup>1</sup>. The later implies the non-existence of links between the 'modern' and the 'traditional' sectors as we saw above. In Laclau's view, under capitalism,

"the modernity of one sector is a function of the backwardness of the other",

which if interpreted, clearly means that development generates underdevelopment. The maintenance of pre-capitalist relations of production in the peripheral areas becomes an inherent condition of the accumulation process in the centres.

Of major interest however is the criticism of Frank's method by Palma (1978). His method of analysis leads him to displace class relations from the centre of his model of economic development and underdevelopment. In Palma's view he developed a circular concept of capitalism, for, the existence of production for profit on the market, is not necessarily a signal of capitalist production. Frank put the origins of capital to expanding world market not emerging free wage labour!

Lall (1975) argued on the other hand that the characteristics to which underdevelopment is attributed

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1. Palma 1978, Op.cit.p. called it 'a mechanico-formal model' which proposed sets of general equilibrium equations, by which surplus at each stage is syphoned off. Palma argues following Cordoso (1974) that the theories of dependency are mistaken because their mechanico-formal nature renders them both static and unhistorical. (p.903).



in dependent countries are not exclusive to them, since they also exist in non-dependent economies. This therefore made these characteristics of capitalist development in general, not necessarily dependant capital features. He identifies two criteria for a concept of dependency to be a theory of underdevelopment; which are: that it must lay characteristics not found in non-dependent ones and that these characteristics must affect adversely, the course and pattern of development of the dependent countries. His conclusion on 'dependence' is that,

"(it) is defined in a circular manner: less developed countries are poor because they are dependent and any characteristics that they display signify dependence." (p.800).

This may be so since there is causality and continuance the problem thereby tending to be circular.

Weiskopt (1976) takes Lall's analysis as a starting point, but concludes that:

"... those aspects of underdevelopment (which writers attribute to dependence) cannot simply be attributed to dependence per se, for they are inherent in the operation of the capitalist mode of production whether or not it takes a dependent form. It is more appropriate to view dependence as aggravating conditions of underdevelopment that are inevitable under-capitalism, than to view dependence as a major cause of underdevelopment".<sup>1</sup>

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1. This particular view will be given more prominence in our discussion on The Political Economy of Zimbabwe in the following chapter.

Perhaps the most relevant contribution to this study is the one made by Chase Dunn (1975) who stated that theories of dependence predict effects of inputs from advanced nations to less developed ones better than neo-classical theories of international economics and sociological theories of modernisation. He uses 'investment dependency' and 'debt dependency' as measures of a country's dependent position.

The relevance of the theory of dependence for Black Africa is tested by McGowan and Smith (1976) who conclude that a modified conventional model would be more appropriate. Walter Rodney (1973) systematically analyses the under-development of Africa within the historical context as a part of European economic development. The fragmentation, loss and destruction of African political, cultural and socio-economic forms over the past centuries was a direct result of European expansion and African underdevelopment. In the health sphere capitalist mining ventures led to the contraction of diseases at a scale hitherto unknown to the traditional societies. European economic activity accompanied by its setting of large plantations and irrigation schemes distabilised the indigenous population's equilibrium with nature. It is notable however, that relative to Latin America, the underdevelopment of Africa within the international organisation of capital is a more recent but no less ferocious phenomenon.



The ECLA<sup>1</sup> analysis shared with the Marxists the conviction that without a strenuous effort to remove internal obstacles to development<sup>2</sup> (ie the traditional sector) the process of industrialization would be greatly impeded. It was distinct in that it made a basically ethical distinction between 'economic growth' and 'economic development'. (Palma 1978) According to this view, development did not take place when growth was accompanied by:

"increased inequality in the distribution of its benefits;

a failure to increase social welfare with expenditure going to the production of luxury consumer durables;

failure to create employment opportunities at the rate of population growth (let alone urbanisation) (Quoted from Palma 1978, p.908)

and finally, loss of national control over economic, political, social and cultural life".

Because this school of dependency went beyond theoretical pronouncements and actually offered packages of policy measures, it attracted criticism from both the left and right. From the left, Frank (1967) and Caputo and

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1. United Nations Economic Commission for Latin America which inspired policies of import - substituting industrialisation in Latin America.
  2. Among the obstacles, Palma in his synthesis on ECLA work, were archaic patterns of Land ownership, low effective demand due to low wages and rigidities in the tax system that made it difficult to increase the public revenues.



Pizarro (1974), criticised it for failing to denounce sufficiently the mechanisms of exploitation within the capitalist system. The right saw it as 'a Trojan Horse' of Marxists with its policy recommendations threatening existing political interests. Its biggest contribution however is its clear identification of the need for national productive and distributive equalisation and efficiency within a conducive social and political climate in a country. There is a realisation of the importance of internal organisation within a country as a crucial first step which values social welfare measures as equally important to provision of employment and creation of productive capacity.

#### Dependent Development View

The changes in international relations in the 1950's, ranging from the ascendancy of the US at the head of the capitalist world, the increasing socialist challenge, decolonisation of Africa and Asia and the growth of transnationals - all meant that a more contemporary analysis of the capitalist system was appropriate. The dependence approach adopted, though comparable to the others viewed above, argued that the central dynamic of the UDCs lay outside their economies and that the options open to these peripheral economies are limited by the development of the system at the centre. It is in this context that the particular development of a nation within a system is conditioned by the general development in the whole system. This realisation is of relevance in

the following discussion on the development process (or the underdevelopment) of Zimbabwe as a particular case. In further analyses aimed at proposing solutions for the problems of underdevelopment the need to understand the alignment of the general forces in the international system, will call for an international analysis in the process of situating Zimbabwe as a country and how it is affected.

Although the approach draws examples from Latin America its analysis of the changes in the international division of labour, capital movement and the emergence of transnationals and their impact on the centre-periphery relations, is relevant to studies of African countries. This analysis sees the struggle for industrialization initially seen as an anti-imperialist struggle, now transform into 'the goal of foreign capital' (Palma 1978). In this view, dependency and industrialisation cease to be contradictory and a path of 'dependent development', becomes possible. The process ceases to be one of imperialism and dependency being 'two sides of the same coin' where the one is reduced to a passive role. It becomes one of:

"forming a complex whole, whose structural links are not based on more external forms of exploitation and coercion but are rooted in coincidences of interests, between local dominant classes and international ones, and, on the other side, are challenged by local dominated groups and classes. In some circumstances, the networks of coincident or reconciliated interests might expand to include segments of the middle classes. In other circumstances, segments of dominant classes might



"seek internal alliances with middle-classes, working classes, and even peasants, aiming to protect themselves from foreign penetration that contradicts its interests!" (My emphasis) (Cardoso and Faletto, 1977 p.10)

A whole chain of relationships is disclosed above.

The analysis should strive to elaborate concepts capable of explaining how the general trends in capital expansion are transformed into specific relationships between men, classes and states. From the above the process proceeds to viewing: how the specific relationships in turn react upon the general trends of the capitalist system; how the internal and external processes of political domination reflect one another in their compatibilities and contradictions; and lastly how, a particular economy is articulated with the centre and how its specific dynamism are thus generated! (Palma, 1978) This type of approach, which concentrates its analysis on 'concrete situations of dependence' (Cardoso, 1974), with full regard to historical realities, attempts to predict a general course of future events and offers a lot of potential for application in countries analyses.

As has been mentioned often in the above discussion, the 'theory of dependency', or 'school of dependency', was developed in response to Latin American problems and attempts have been made to extend and develop analyses for the African countries. Samir Amin (1974) raised the question of whether capitalist development can occur at the peripheral countries; and Wallerstein (1970) made several contributions on the way dependency



theory applies to Africa.<sup>1</sup> MacGowan and Smith (1978), who carried out a study of thirty African countries, contend that the African countries have not yet reached the 'threshold' of dependence. This implies a specific stage before which the application of dependency theory cannot be supported or shown to work.<sup>2</sup> Caporaso criticised this approach for errors of conceptualization and methodology because the model disregarded the historical influence of global capitalism on peripheral societies. Leys<sup>3</sup> (1975, 1978) on Kenya deals with dependency in the state context and focused on the impact of external links on the state and social classes. He sees the movement of capital, its effects on the development of capitalist relations of production and capital accumulation, in particular historical circumstances, as the real issue. In his view in Kenya, capital accumulation has allowed some capitalist development and a national bourgeoisie, which is not comprador has developed with interests in industry, commerce, finance and farming.

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1. Quoted in Lenneiye, M.N. (1980) (op.cit.p. ): "Accumulation on a World Scale: A critique of Theory of Underdevelopment". translated by B. Pierce, Monthly Review Press, New York, 2 Vols.: Wallerstein, I. 1970 "The Colonial Era in Africa: Changes in the Social Structure" in Gana, L.H. and Dingnan, P. eds. "Colonialism in Africa 1870-1960 Vols.2, Cambridge University Press, London.
  2. Lenneiye, (1980) - p.21 shows the 'threshold' graph with Latin American countries past it and African countries not having reached it.
  3. Leys, C. (1978) "Capital Accumulation, Class Formation and Dependency. The Significance of the Kenyan Case". Queen's University of Kingston, Canada.

It is Kaplinsky (1979) who disagrees with Leys and the others who subscribed to his views. Kaplinsky points out that the indigenous capitalist class has obtained some benefits from accumulation because of its alliance with foreign capital. He sees this alliance, which is bound to be temporary, as limiting capitalist development in the peripheral countries. Warren (1973) suggests the possibility of independent industrialization at the periphery but within the framework of imperialism. This denounces the Frankian view of, the infeasibility of development and instead sees 'the development of underdevelopment'. It is however significant that both approaches realise that:

"the process of underdevelopment necessarily sinks the majority of its people into even greater poverty" (O'Brien 1975).

The vicious circle of poverty (as depicted in Diagram 2:2) can be seen to be a direct result of the underdevelopment of the majority indigenous populations in UDCs through capitalist development. The demands of capital for more and more raw materials for industries, in the centres and the metropole led to increased demands for land (plantations and farms) and labour for the commercial farms and mines. Since the stock of available land is fixed, any increase in their land-holding led to a decrease in available peasant land and the marginalisation of the peasantry which precedes proletarianization. With urban expansion too, land and

DIAGRAM 2.2

THE VICIOUS CIRCLE OF POVERTY



Source: Jenkins, Rhys  
"UNDERDEVELOPMENT"  
Development Studies Reprint No.41, 1977  
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the able bodied were taken-up. The fertile land went first, which led to food shortages among the majority of the population. This in turn, weakened the population making the people susceptible to disease. Their health culture and their environmental equilibrium are disturbed with the net result that their productivity diminishes. That necessary effort, which should be generated at base, consequently will not be forthcoming, thereby failing the development process.

Most underdeveloped countries are trapped in this vicious circle with the full participation of those of their nationals who have joined the exploiting ruling and governing classes. Capitalism would not survive without these tentacles. The crucial factor here is the fact that this alliance does not reduce, but instead, it increases these countries dependence on the world economy in whose running they do not participate. Any adverse effects therein are pushed to the workers and peasants for the benefit of the national bourgeoisie who are acting for the ultimate beneficiaries - international capitalists. Every now and then these two quarrel because basically their interests, though seemingly the same, are antagonistic with the former struggling for total local control of the industrialisation process and the latter, wanting to retain control of all activities.

In our search for ways to break out of this vicious circle, we postulate that health should be used as the 'entry-point' and that it indeed can act as a potent

lever for development. Attempts by the advanced countries, which can at most be described as half-hearted efforts, have been made in the form of aid and technical assistance, to set-off developmental activities. These efforts have had serious adverse effects which we want to highlight.<sup>1</sup>

Le Brun states that:

"the primary function of aid is thus to balance the external accounts of the Third World. The world economic system would break down without it" (p.285)

Furthermore, and more relevant for the UDCs, all too often, it fosters irresponsible attitudes among national officials, since the population has no mechanism of supervising its utilization. It is deliberately used by the donors to perpetuate obsolete and unsuitable structures from which they, and not the nationals, benefit. The experts that accompany aid and technical assistance are knowledgeable about their developed countries and patterns therein, they tend to therefore apply erroneous policies, because they lack imagination and have no knowledge of local conditions. Since they always want to use the equipment they are familiar with,

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1. Olivier Le Brun: "Fundamental Aspects of Underdevelopment and aims of development". Unesco. 1973.

this serves as an efficient instrument of capitalist expansion. Most invariably, the advanced countries' cultural, political and ideological models will be disseminated and imposed in complete disregard of recipient countries' dominant cultures. Aid, in short, has increased the poor man's burden. It always finds its way back to the developed countries, with interest, and leaves behind a trail of devastation and misery. Real development, C.T. Kuriel and Gunnar Myrdal (1968) observe, should be rooted in the socio-cultural base of the people and be a product of the aggregation of the people's aspirations and expressions. This amounts to "the movement of the whole social system upwards", <sup>1</sup> the simplest definition of development.

Have the theories of under-development assisted in identifying the gap between the situation in the UDCs, and what constitutes development or how a nation embarks on a process of development? They have enabled us to understand how the present situation in these countries arose. Through their methods and approaches, we have been able to situate the individual country in the global context. They provided an array of tools from which to choose. The broader environment and its dictates are now in perspective and how they relate with the internal forces - more importantly, how they led to the creation

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1. Myrdal, G. 1968 "Asian Drama; - An Inquiry into the poverty of Nations". New York. Vol.3, p.1868.



of the internal structures, has now been articulated. The issue now remains one of resolving the internal disparities, disequilibria and tackling the adverse effects of capitalist development. Underdevelopment was generated from external forces, development has to be fostered from internal forces. In effect, the issue becomes one of breaking the vicious circle of poverty which manifests itself in the deplorable state of health of the majority of the population within the country.

The important factors to emerge from the above discussion are that the development process is political, cultural, socio-economic in nature; thereby requiring a multi-disciplinary integrated, holistic approach. For the process to succeed, it must be rooted;

"at the local level and in the praxis of each community".

This means in effect that, it must involve the lowest of the community who are the majority, willingly. The differentiation which exists in the traditional societies should be addressed to in order that, with increased contact and participation in the wider productive sector, it does not grow into gaping class differences detrimental to development. Herein lies the strong political nature of the activities built into the process of development. The use of active political organisation and structures in the community

must be the basis for rallying participation in positive development. The activity which brings people together most easily and with the most potential, in our view, is health. This then would make it an 'entry-point' to and a 'potent lever' for development.

The discussion on defining development emphasised that as a process, it must address itself to:

".. man, each man and each group of men, and even include the whole humanity" (C.T. Kuriel)

The supporting diagram (p. ) also illustrates the priority needs which if met, lead towards development. These include health, but what is it about health that renders it most ideal as 'an entry-point' to development?

## HEALTH IN DEVELOPMENT

The World Health Organisation (WHO) defines health as

"a state of complete physical, mental and social well-being and, not merely the absence of disease and illness." <sup>1</sup>

These elements are central to the understanding of health, and by their nature, call for a comprehensive and integrated approach to health. They highlight the fact increasingly becoming known, that:

"the determinants of health in the future and in all countries, sooner or later, will be behavioural, environmental and nutritional." <sup>2</sup>

This conforms with what has been viewed above as requirements for the initiation of the process of development, especially the multidisciplinary nature of the components. The components also show that the health system is a sub-system of the wider human system. In terms of health sectoral activities, this means that as a ministry, it contributes just as much to the developmental effort, as any of the production ministries. It is essentially because the health sector has always been viewed as a service sector that its contribution to national development has been minimised.

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1. Development Dialogue: 1978:1; "Another Development in Health". p.9.

2. Ibid p.10.



At the international level, the health status of the millions of inhabitants of the UDCs led to the interest in their welfare and to the opening of the discussions on the underlying causes of under-development. The widespread poverty in these countries which manifested itself through high infant and maternal mortality rates, low life expectancy, low productivity, morbidity, illiteracy and low incomes - depicted in the vicious circle; were made vivid by the comparison of these figures, with those of the developed countries. See Table 2.3. The gross divergencies in the quality of life enjoyed in developed or advanced countries and in the under-developed countries led to the pressure for discussions on how to narrow the gap.

As observed in the discussion above, because capital penetration caused a wide disruption of traditional life and modes of production, wide disparities in access to wealth and means of livelihood emerged. Through the capitalist tendency to align with the ruling national classes, it widened differentials in backward nations and marginalised the peasants. In the UDCs where mining was started (as in the case of Zimbabwe), practices of forced labour were introduced which led to separation and break-up of families when the able bodied left to work in the mines.<sup>1</sup> Where farming was the main

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1. See the following chapter on 'The political economy of Zimbabwe', which includes discussions based on/...

TABLE 2.3

	Average per capita GNP (\$)	POLI	Life expectancy at age 1	Infant mortality	Literacy %
<u>Low-income Countries</u>	152	39	48	134	33
India	140	41	50	139	34
Kerala, India	110	69	61	58	60
Sri Lanka	130	83	68	45	81
<u>Lower Middle-Income Countries</u>	338	59	61	70	34
Malaysia	680	59	59	75	41
Republic of Korea	480	80	61	47	88
Cuba	640	86	70	29	78
<u>Upper Middle-Income Countries</u>	1,091	67	61	82	65
Gabon	1,960	21	41	178	12
Iran	1,250	38	51	139	23
Algeria	710	42	53	126	26
Taiwan (ROC)	810	88	69	26	85
<u>High-Income Countries</u>	4,361	95	71	21	97
Kuwait	11,770	76	69	44	55
United States	6,670	96	71	17	99
Netherlands	5,250	99	74	11	98

Source: A Research Note - A Physical Quality of Life Index(POLI),  
 taken from Sewell, J.W. - THE UNITED STATES AND WORLD  
 DEVELOPMENT  
 New York, Praeger Publishers,  
 March 1977 (IDR,1976/49), p.34

TABLE 2.4

PERCENTAGE DISTRIBUTION OF DEATHS BY CAUSE IN TWO SELECTED MODELS

CAUSE	DEVELOPING COUNTRIES	DEVELOPED COUNTRIES
INFECTIONS, PARASITIC AND RESPIRATORY DISEASES	43.7	10.8
CANCER	3.7	15.2
DISEASES OF THE CIRCULATORY SYSTEM	14.8	32.2
TRAUMATIC INJURY	3.5	6.8
OTHER CAUSES	34.3	35.0
ALL	100.0	100.0

SOURCE: Adapted from POPULATION BULLETIN OF THE UNITED NATIONS No.6  
(New York, United Nations, 1963) pp.111-112.  
Quoted in World Bank, February 1980,  
"HEALTH: Sector Policy Paper", p.13.

Note: The models simulate the pattern of disease under specific assumptions regarding population characteristics, environmental conditions and socio-economic circumstances. As illustrated in Table 2.3, in the developing country, the life expectancy at birth is low and connected with underdevelopment; whereas for developed countries, there are diseases of degeneracy as well as high life expectancy and an old population structure.



activity, peasant fertile land was expropriated. This meant that the indigenous population was displaced to areas which did not yield sufficient food. More importantly for the process of development, the dominant cultures were destroyed. Traditional community organisation, values, habits and forms of production were replaced with alien standards, politics and norms. The resultant disequilibrium with the environment, and within the community, led to illhealth and poverty, more seriously to loss of social power over themselves by the community. These trends are best analysed in particular countries, suffice here to observe the cumulative effect of measures taken earlier in history on health.

Two forces are identifiable which brought health to the forefront in UDCs. The first was to do with the interests of capital. Because productivity in the various sectors from which its profits were coming continued to fall due to absenteeism and low productivity because of illness;<sup>1</sup> capital had to have an interest in the health of its labour force. Consequently the workers' appalling health condition led,

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.../Charles Van Onselen, 1976; "Chibaro, African Mine Labour in Southern Rhodesia 1900-1933". This gives a graphic account of forced labour on the mines and how it affected the health of indigenous workers firstly and the peasant population by spread.

1. A vicious circle phenomenon. See p.

in the UDCs, as previously in the 19th century Britain, to the closer examination of working conditions and subsequently when workers became vociferous; to legislation stipulating minimum requirements at work, improvements in public health measures, health education and literacy campaigns. Although these measures were initially at work places and in urban areas, infections spreading from rural areas (reversing the original spread trend) with which the workers have constant contact, meant that more had to be done. Herein lies the origins of the skeletal rural health infrastructure found in UDCs. This accounts for the provision, though still low, of other social welfare facilities and the overall generation of other productive activities emanating therefrom.

The second force accompanied the drive for political independence from the colonial powers. Although this aspect is dealt with at length throughout the study, mention can be made here of the fact that the rural people have played a very important role in the fight for independence in all UDCs. This is because they have suffered most from imperialist expansion of capitalism. Most obvious will be the conditions of complete deprivation: lack of adequate food, rampant malnutrition, poor housing, insanitary surroundings, polluted water sources and lack of land on which to grow food which they have experienced. The nationalist support stems from articulating the link between this

condition and colonial rule. In the process of rallying the masses' support, their consciousness is raised and they become aware of the causes and nature of their condition. This invariably leads to the demand for a better deal - the first contradictions within capitalist development begin to manifest themselves. When therefore a nationalist government takes measures to improve the lot of these rural populations' condition by, for example, improving their transport infrastructure, giving them more land to till, setting up clinics and schools, etc, this amounts to:

"ways and means of transferring authority from the ruling classes,<sup>1</sup> the governing, the centres; to the rural masses".

Health is therefore seen to enable articulation of the need for equitable economic, social and political power which are essentials in the process of development.

WHO's Sixth Report on the World Health situation (World Health Forum 3(2); 1981 p.273) observed that:

"... the priority health problems of mothers and children and high levels of mortality and morbidity, derive to a large extent from the synergistic effects of malnutrition, infection, environmental and socio-economic conditions, including unavailability of health care".

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1. Development Dialogue, 1978 (1).



Here equal weighting is given to the possible impact of preventive and promotive measures which include socio-economic interventions; as is given to curative, high-technology specialist oriented care. It was essentially the distorted view that the more curative centres a country had, the better the health of its population; that led to the rocketing of national health budgets. Given the scarcity of resources in any country, increasing health expenditure on curative services, has led to calls for a change of emphasis, essentially because it has not been accompanied by a better level of health for the population. The earlier conception of health as being capable of being delivered has come under fire and is increasingly failing to meet the requirements of the nations. Only by recognising the equal importance of preventive and promotive activities of the individuals, the community and the nation as a whole can any significant advances in health be forthcoming. This necessarily requires grassroot participation. It is therefore intended in this study to demonstrate how grassroot participation can indeed generate activities which will not only improve the real health of the rural poor but also set in motion activities that lead to the nation's development. This is only possible through a clear understanding of the forces that are at work economically, politically and socially at different levels and developing strategies to counter them both nationally and internationally.

In Part IV a model is proposed which addresses itself to all the factors identified in this chapter. In the next chapter the political economy of Zimbabwe is examined with two prime objectives: firstly, to view in some detail, the position of the country in the light of the discussions on underdevelopment, with the intention of disclosing the role of international capital, the national bourgeoisie and the indigenous petty-bourgeoisie converts; secondly, to bring out features in its evolution which show the place of health and health related issues in its evolution, which need to be addressed to, if planning and management of Zimbabwe's health is to be a 'potent lever' for; 'an entry point' to; development. The second objective will highlight those features which the metagame method as an aide in planning and management decision-making, among other things, will address itself to.

CHAPTER III

THE POLITICAL ECONOMY : ORIGINS AND GROWTH OF CONFLICT  
IN RHODESIA

"First, the whiteman brought the Bible, then he brought guns, then chains, then he built a gaol, then he made the native pay tax. Were they told to do this in the Bible?.... It is because the white man wants more money". J.M. Mphamba, addressing a meeting of the Industrial and Commercial Workers Union in July 1929.  
(Quoted in Charles Van Onslen: "Chibaro: African Mine Labour in Southern Rhodesia, 1900-1933". Pluto Press, 1976 p.195)

"The system in disposing of a man's labour power, would incidentally dispose of the physical, psychological and moral entity 'man', attached to that tag. Robbed of the protective covering of cultural institutions, human beings would perish from the effects of social exposure. They would die as victims of acute social disclocation through vice, perversion, crime and starvation." (Polanyi, K. "The Great Transformation; the political and Economic Origins of Our Time." New York, 1944, p.73.



(i) Introduction

The historical background, Chapter I established clearly that from the arrival of the settlers, the issue of land became crucial to the understanding of the pattern of labour supplies, capital accumulation and the health of the indigenous population. Although the reasons for land grabbing were not to force the African population into labour;<sup>1</sup> after settling, it became necessary for the settlers to have the labour. Labour needs or requirements over time, were the direct result of land grabbing and the failure to easily realise gold from the mining claims; not the cause. The speculative and commercial value of land lay in what it could yield in gold and only later, as a home. It therefore was a spur to all activity.

The first settlers' graphic accounts on the situation in Zimbabwe of food abundance, iron implements works, trade and exchange, all indicate a mode of production which cannot be called feudal; if put in the context of customary law, which formed the basis of rights to land. It was a communally based mode of production with extended family ties reducing individualism to an insignificant level. Settlerism interfered with this natural development, which was endogenous and

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1. Palmer (1977) criticises Jack Woddis who asserts that: the essential reasons behind expropriation of land in Africa were, to prevent the African peasant from becoming a competitor to the European farmer and to impoverish the African peasantry so as to force them to work in the mines and farms. This did not constitute a prime aim although in the end it became the net outcome of land acquisition in Rhodesia.

self-reliant. More interestingly, the production mode did not make the African trade subject to the dictates of the international market, although external trade was well developed. The psychological effects of the brutal sweeping away of this heritage, and the physical disruption of normal village life, all added-up to undermine African confidence and interfered with its growth to fullness. Nowhere else was this feature more noticeable than in the people's state of health, the pace at which health services were instituted and the reactions by the different groups, to attempts at 'solving' the health problems. In short, political, economic and socio-cultural distabilisation have their most manifest impacts on the state of people's health. What was historically the pattern of this build-up? Why did this pattern take a more ruthless path in Rhodesia than anywhere else in Black Africa? What forms did this "brutal thrust which took away from the Africans control over their progress", take?<sup>1</sup>

In the foregoing chapter, the possible theoretical frameworks of analysing the particular situation of Zimbabwe were examined. It is the view here that the various approaches discussed, may have some partial relevance to different periods of Zimbabwe's history.

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1. Brunshwig (1963) Quoted in Mabogunje, A.L. 1980 "The Development Process: A Spatial Perspective". Hutchinson University Library for Africa. London p.47.



It is postulated here, that the predominance of political forces in the minds of those who set-up the Company, was also shared by the settlers who were encouraged to move into the country by the company. With time and the influence of events elsewhere in the region, especially South Africa where the settlers had their background, these political forces and ideals, found expression in the doctrine of "African subjugation" and "no poor whiteism".<sup>1</sup> The strength of this political distinction between white and black, heavily influenced the two races' differential access to economic power and other forms of social power. The impact of South Africa on Rhodesia was so much as to constitute a centre within the periphery of capitalism. This feature remained and was exacerbated under UDI. Race and colour hence dominated Rhodesian political, economic and social trends.

International capital knows no colour bar, but it tends to side with the predominant group, so as to gain the necessary leverage to enable it to exploit the economic benefits. Capital's emphasis is on surplus extraction and as Marx stated, it has its own internal dynamic which enables it to reproduce. One of its most notable reproductions is class differentiation. This

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1. Kay, G. 1972.



determines who influences and constitutes the governing class and the ruling class. The Colonial Office had taken upon itself, from the time of the suppression of the "Risings", to oversee the running of affairs by the Company<sup>1</sup> in Rhodesia. What was the nature of the policy that emerged from a marriage between a Colonial Government and a Company Board of Directors? The strengths of political and economic motivations in the growth of the country are noticeable, how did these interact in the process of class formation that ensued? What was the role of the state in the process?

The impact of the combination of these factors, as we observed in Chapter II, is to underdevelop a nation, which process is manifest in the state of health of the population. With African reserves scattered in the outlying areas it was not reasonable to expect the Company Administration to have records on their health situation. The areas which provided the possible contact were the mines, farms and the rail and road construction centres, where they came into contact with the whites. All the land on the highveld and twenty-five miles from any railway line was white area, it is therefore postulated that the growth of the health services was closely related to white economic

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1. The Company refers to the British South Africa Company (B.S.A.Coy.) formed by Cecil John Rhodes.

activity and settlement pattern not to the need to treat and care for the indigenous population suffering from the policies of the settlers of land expropriation, forced labour and taxation. White political, economic and social imperatives dictated the growth of the health sector.

The intensity of the suffering that followed capitalist development in Zimbabwe, because of the particular politico, socio-economic structures which emerged, led to the adoption of an equally difficult, painful and no less intense solution. The problem was created by political demands, it is political requirements which resolved it and which will finally determine the pace, nature and tempo of the development process to be undertaken. Since the African indigenous population fought in the 19th century so bravely and gallantly, against all odds, to preserve their political, economic and socio-cultural power, but lost; their equally gallant and successful fight in 1980 should denote the beginning of a fresh search for the power which will enable the growth of every Zimbabwean to fullness.

The discussions below will attempt to answer the questions posed above under four subheadings: the period of colonial rule and Company Administration, the process of class formation, the growth of conflict and the growth of the health sector. It is hoped to systematically analyse the situation up to the time of the final conflict.

(ii) The Period of Colonial Rule and Company Administration

The Chimurenga Wars (1896-7) have been described as:

"the most violent, sustained and highly organised instance of resistance to colonial rule anywhere in Africa ... a genuine people's war, in which individuals fought because they chose to ... .

A wide cross section of the society was involved,<sup>1</sup> not merely .... simply the official army."

The British Government's reaction was correspondingly appallingly ferocious and indifferent to suffering. In Mashonaland, they dynamited caves and hunted down the rebels.<sup>2</sup> In Matabeleland, Rhodes had to talk the Ndebele out of the Matopos hills with promises of a fairer deal. The memories of these wars, provided inspiration for the Liberation Struggle - the second Chimurenga War - which finally brought African majority rule in 1980. Palmer draws the conclusion that the pattern of the uprisings suggests that the loss of land was not a decisive African grievance that led to the war, since, chiefs who had not got their lands alienated fought, and some who had their lands taken did not. He puts the decision to fight or refrain, to have been "a result of internal Shona politics".<sup>3</sup>

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1. Palmer, R. 1977 p.55.

2. Ranger, T.O. 1970 p.1. The Shona, religious and secular leaders refused to surrender.

3. Here Palmer is effectively disputing claims that the Shona were a "politically fragmented people", as quoted in Chapter I, p.



A lot of contributory factors observed in Chapter I, led to the decision. These included the psychological impact of bands of white men searching for gold all over without any apparent form of control, hunters shooting game and settlers setting up home in African chiefdoms without prior consultation, forced labour on mine sites, driving wagons and laying rail tracks. It was an invasion on the African way of life which they could not take any longer.

The Risings were very costly in men and money to the Company;<sup>1</sup> they were much higher than anywhere else in a comparable revolt. The costs incurred increased the Company's stake in the country on the one hand and strengthened the resolve in the white settler community that they had won and sacrificed white blood, to make Southern Rhodesia their home. The two called on the colonial power to sort out the mess they had got themselves into. Their hope was that after suppressing the 'rebellion', the Crown would leave them to continue where they left-off! The Colonial Office this time took a different view.<sup>2</sup> It consolidated its position by appointing a Resident Commissioner to be based in Salisbury with the power to approve appointments of

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1. Palmer op.cit. notes that 372 Europeans were killed and 129 wounded, a figure of 10% of the total white population. p.55.

2. Chapter I, p.11. The Crown had hesitated to move into Rhodesia because of political and logistical problems.

Native Commissioners (NCs) and to approve Ordinances proposed by the Legislative Council (Legi Co). He was to take charge over Native Affairs to ensure no further 'rebellion' occurred and to see to it that the Company improved its Administration of Native Affairs.

The highly sensitive nature of Native Affairs required that the Crown appoint an experienced man with the advice of the Company. The men appointed notably had experience in South African native affairs. These included William Milton who was a senior Cape civil servant and expert on 'Native Affairs'. The Company also drew from the pool of South African experience for its administrators. In effect therefore, Rhodesia was run as another case in the South African experience, a form of fifth 'province'. The creation of Native Reserves, a policy adopted by the British as a temporary measure, to ensure that the Africans could be closely monitored, had its origin in South Africa where they were designed to protect Africans from land dispossession by whites. They indicated the extent of land alienation which had occurred since they carried the conotation of land 'left over' by Europeans. In essence, it meant the Africans lost much of their land. The Jackson Land Commission (1920-1) in Nyasaland observed that the policy of Reserves was:

"an unwarrantable inteference with the free occupation by the people of their native land and would in addition, be totally unsuited

to their manner of life. Their movement ....  
.. would be a great hardship".<sup>1</sup>

J.H. Taylor expressed the view that Reserves,

"involve the negation of all progress, and  
should be regarded as a temporary make shift".<sup>2</sup>

On the other hand were those who argued that they  
provided a place where the natives,

"can escape being rack rented".<sup>3</sup>

This was equally applicable to Rhodesia but a major part  
of British and Company policy consisted of continued  
implementation of the idea. Whereas the British saw it  
as a temporal measure, the Company saw it as a permanent  
feature of African life. The settler view fluctuated  
from the 'prolitarian school', who advocated that  
natives should be allowed to remain on European farms,  
mines and towns with their families thereby forming a  
permanent worker-class; to those who wanted them to be

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1. Nyasaland Protectorate: "Report of a Commission to Enquire into and Report upon certain matters connected with the occupation of land in Nyasaland Protectorate". Zomba 1921. Quoted in Palmer (1977) p.57.
  2. He was Chief Native Commissioner for Matabeleland in 1904, another one was in Mashonaland.
  3. South Africa: "South African Native Affairs Commission 1903-05", Vol.IV, Evidence of Sir M Clarke (1904), Cape Town, 1905.



drawn into the capitalist money economy when needed, while permanently based in the Native Reserves - the 'migrant labour' school.<sup>1</sup> These opposing views demonstrate the contradictions that arise as a result of the impact of capital penetration into a 'backward nation'. Philip Mason (1958) in 'Birth of a Dilemma', summarises the deepest insight into the hidden effects of capitalist penetration in the context of Rhodesia when he states, regarding the native population's future, that they:

"would gradually come to be integrated into an economic structure based on class instead of race".

Politics continued to press however, for the reverse - race determining class! The latter being relevant within the former.

The intention of capital, as we shall see under the section on class formation was to turn the Africans into wage labourers rapidly through making them landless. This was the 'doctrine' (Mason 1958), which has universal application in Marxian conception of capitalist development - once the economic base is established, it determines, corresponds to or conditions the super-structures - ie the political and socio-cultural factors.

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1. This is discussed in Charles Von Onselen, "Chibaro; African Mine Labour in Southern Rhodesia 1900-1933" (p.76-77). Pluto Press, 1976.

This seemingly smooth path of Capitalist development seems to have been interfered with in the Rhodesian particular experience. This is attributed to the changing power relations and situational perceptions between the colonial power, the Company and the Settlers; most of which had to do with the position of the Native African population.

Table 3:1 shows the Reserves situation in the two provinces. In the case of Matabeleland, practically the whole central highveld was in European hands. (Palmer p.69)! The Resident Commissioner expressed the difficulty of finding suitable land. Even the Chief Native Commissioner (CNC) a Company Administrator, admitted that NC's under him had been driven to select land 'not altogether suitable for reserves', and that, where some Reserves appeared large,

"this is mainly accounted for by the fact that they had to select ground<sup>1</sup> with granite and ground unfit for cultivation".

The Company administrators in the earlier days had left no tillable land available for allocation into Reserves which had to be set aside for the Africans moved out of areas granted to white settlers.

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1. Palmer, p.70.

TABLE 3.1:

THE NUMBER AND SIZE OF RESERVES IN 1902

PROVINCE	No. OF RESERVES	ACRES IN (millions)	% OF PROVINCE
MASHONALAND	80 + Mtoko District	17.1	37
MATABELELAND	16	7.7 <sup>(a)</sup>	17 <sup>(b)</sup>

SOURCE: Palmer, R. 1977, "LAND AND RACIAL DOMINATION IN RHODESIA",  
Heinemann Educational Books, p.67

Notes: (a) Of this total, 5.3 million acres comprised remote, waterless and largely uninhabitable Gwaai, Shangani and Nata Reserves (Palmer, 1977, p.68)

(b) In 1898, 38% of the Matabeleland African population lived in the Reserves; by 1976, the proportion had risen to 80% (Riddell, 1978, p.7)

By 1899, an estimated 15.8 million acres of land had been granted to Europeans. This represented 1/6 of the total land area of Southern Rhodesia. Categories of land, which could not be selected for reserves included land on the gold belt, near existing or projected railways and, in some districts, land that could easily be defended in the event of another 'rising' - for example, kopjes (rocky hills).  
(Palmer, 1977, p.67)



In the attempt to comply with the Crown's requirement to create Reserves, the Company Chief Administrators Milton and Grey found that there was no land left following the indiscriminate granting of land by Jameson to individuals and companies. The Company therefore decided to obtain it from elsewhere, the choice then being absentee landlords, in particular the syndicates and companies. It called for beneficial occupation or surrender. Because many settlers were on these syndicates and or held shares in the companies, the settler representatives on the Legislative Council opposed the move. At that time Rhodes badly needed settler support to shore him from the post-Raid pressures; at a later point it was the Crown's turn to solicit the settler support in the midst of the South African War, therefore the settler objections to action against absentee landlords was upheld! In the end, only a small proportion of the unoccupied land was surrendered despite the fact that only one million acres out of the total of 8 million acres owned by these companies was being developed! To date the legacy of absentee landlordism continues to give the government a headache and the African population feel incensed!

So, the land policy being what it was, many Africans found themselves tenants on white farms required to pay rent or to move to barren, rocky uncultivable reserves. This was the beginnings of a new form of forced labour (they certainly did not have the choice of free labour) devised to provide for the labour requirements on the mines, farms or in construction. One direct result of British rule was the

discontinuance of this practice in which NC's participated. They were instructed not to participate either directly or indirectly. This problem of labour shortage to be dealt with under class formation, led to the introduction of a stream of legislation in a bid to proletarianise the African peasantry. The measures undertaken, ranged from taxation to low pricing of African produce, in a bid to compel the Africans to become workers. The unity of purpose here between the Company and the settlers was unquestionable and the tendency to go to the extremes of forced labour was strong. The Colonial Office, because of its prime concern for no further rebellion and because of philanthropic groups' pressures at home, resisted the demands for excessive taxes and indenturing of African labour. So eager were the Company and the settlers that they experimented with labour from as far afield as Arabia, Abyssinia, Somalia and even considered Chinese labour!<sup>1</sup>

The period between 1896-1908 was a false boom period for the Africans. Cripps (1903) notes that the Shona farmers would produce in good season, "a great surplus of grain for trading". They put all their energies to producing a surplus so as to meet their tax commitments and, as Vambe (1972) in "An Ill-Fated People" puts it, they believed that self-sufficiency in their own food supplies was essential to their limited freedom.

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1. Charles van Onselen, p.81.



"As long as they grew food for themselves, they were spared the humiliation of working for white men".

Clearly, to the African, self-sufficiency in food production made one a 'complete' human being. It gave one pride and self-confidence, a measure of social and political freedom whose loss only meant irreparable psychological damage. The way the Africans regarded worker status as humiliating says a lot for how they looked upon themselves when they had got to the point when they had to work! Only the last stage of need forced them to seek employment - survival; such was the extent of the dehumanising effect of capital penetration or capitalist development in Rhodesia on the indigenous population. As the discussion following, on growth of conflict, will show, to restore mining viability, the mining companies and mine owners had to progressively reduce wages, as they systematically forced the Africans into reserves with nil agricultural potential. Their aim of economic development could therefore be only achieved if accompanied by corresponding underdevelopment of the African peasantry so that labour supply would exceed labour demand in the mines, on farms, in construction and manufacture, thereby increasing profit margins. In effect, human growth was made subservient to or became the obverse of economic growth in the peripheral centres. Frank's assertion that Capitalist development was not possible in the periphery was therefore being fast eroded in Rhodesia.



Palmer makes an interesting observation that the conscious withholding of labour (the opposite of free labour) by the African native population, meant that Rhodesian employers - of which the Company was the major one - had to rely heavily on Chibaro<sup>1</sup> migrant labour from the north. The local Africans then depended on local agricultural produce which was even exported. This was the situation in Mashonaland before the population pressures had begun to bite. Comments from the NC for Lemagundi, that,

"the native is in the position of an independent landed class",

and the NC for Makoni, that

"the average Shona does not require to look for work," (Palmer 1977, p.78)

were not well received by the Company and the miners who were short of labour. Although this might have brought a smile and a sense of achievement at the Colonial office that the natives were now pacified; the NC's were

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1. Initially it referred to Contract Labour brought in by the Rhodesia Native Labour Board recruited from outside, at the beginning, and inside later, under long term contracts of work. It however had its origin in Natal where it referred to forced labour. In Rhodesia the Africans used it in derisive terms to mean 'slave status' imposed by the long term contracts enforced through the Masters and Servants Ordinance - also hated by the black mine workers. Charles van Onslen, 1976, p.99.

were not pleased given their South African background, and their Company affiliations. It is said that,

"they preferred the<sup>1</sup> noble savage, to the passive unmanly farmers".

In addition, it was the lack of European competition which enabled Shona agriculture to flourish supplying the mines and the construction workers with food. European agriculture in 1903-04 accounted for 10 per cent of the total market output.<sup>2</sup> Palmer concludes that most Europeans found it profitable to trade in African produce than become producers themselves. This accounts for the relative satisfaction with the continued African occupation of the land they farmed. The situation was dramatically changed in 1908, when the Company adopted a 'European Agricultural policy'. Why would the Company have wanted a European Agricultural policy seeing as we have done above, that African agricultural produce was enough for the internal market with a surplus actually exported?

The BSA Company had been formed to exploit the Second Rand. Its owners had for fifteen years invested very

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1. Chanock, M.L. "The Political Economy of Industrial Agriculture in Colonial Malawi: The Great War to the Great Depression," Journal of Social Sciences I, 1972, p.117.
  2. Clarke (1977(a):15) noted that Europeans farmed only 4% of cultivated land by 1904. (Quoted in Riddell : The Land Problem in Rhodesia" 1978, p.11.

heavily in mining, but figures show that in 1910, ten leading gold mines produced a profit of £614,000 against £7m from eleven Rand mines.<sup>1</sup> Furthermore, before the hopes for a Second Rand had sank, the Company had undertaken a Railways Construction investment which cost it millions and virtually opened-up the whole country. In 1897, Bulawayo was linked to South Africa through Mafeking and Botswana, 1899 Salisbury was linked to the Indian Ocean at Beira, 1902 Salisbury and Bulawayo were linked and in 1904 Bulawayo was linked to Fort Victoria. The whole highveld was therefore well served with transport intended initially to ferry the gold and mineral output. It is therefore the desire to recover the heavy original outlay that enduced the company to promote Commercial Agriculture and get the settler farmers to produce something, to develop the country, create demand and open it to foreign investors; thereby increasing the value of the Company assets in the Railways, the Mines and in Land. As an agent of international capital, it was doing what it was most capable of doing; promoting capitalist economic development with its demands for labour which could only be obtained by proliterianising the peasants, through making their agriculture unprofitable.

The Europeans initially obtained maize seed from African

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1. Arrighi, G. "The Political Economy of Rhodesia"  
1967 Heineman Ltd.



peasants so that in the early years, they farmed in a

"primitive and extensive fashion, so that (their) yields were little<sup>1</sup> better than those of the African peasant".

The same applied to tobacco which interested investors very much because of its quick returns on capital invested. It attracted immigrants in no time - and since it grows in sandy soils, the Company stood to benefit double; first, from the investment capital which raised its countrywide assets value; and secondly, it could now sell many of its poor soils farms. Palmer observes that soon maize was being exported back to Britain and by 1924, 78% of European land under cultivation was devoted to maize. With tobacco, in a few years time the farmers were overproducing the crop!

Having effectively got the agricultural policy under way, the Company turned its attention elsewhere, encouraged by the speed with which returns had started flowing in. It now required more land to bring under cultivation and also to force free labour on to the market for now it was required in both mining and agriculture. It saw the chance of doing this in one move, the attack on absentee landlords, on whose lands the Africans were farming, paying rent and making sufficient surplus to cover the rent, and taxation. In 1908 it obtained the passing of

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1. Palmer 1977 p.93.

the Private Locations Ordinance, which pushed the rents dramatically up. The landowners offloaded the rent increase on the African tenants, who had no choice but to move into the unsuitable reserves or become workers. To tighten the screw further, the Company followed the rent on unalienated land with a dog tax in 1912, and a dipping fee for cattle in 1914. Commenting on the ferocity of the Company onslaught, Marshall Hale, in 1912 wrote:<sup>1</sup>

"These companies seem determined to get their pound of flesh".

Nor did the matter end there, the Company wanted the Reserves reduced in size. They fought for a Commission which they finally got established (The Native Reserves Commission) in 1914. When it assembled, it is ironic that exactly one year had passed after the Native Land Act in South Africa which proclaimed 'segregation' was to be official land policy there. Its effect on Company and settler pressures on the reluctant Crown are obvious.

Because hostilities had broken out in Europe, the Crown wanted a lot of goodwill all round, so it conceded. The Company was slowly fulfilling its ambition of reducing the power of the Imperial Government in Rhodesia. Aware of the Colonial Office's opposition to its assuming more

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1. Quoted in Palmer p.97 he was Secretary to the Administrator Milton.

say, it had systematically fought for the extension of settler say in the affairs of the country through representation in the Legislative Council (Leg.Co.). Changes in composition show that: in 1899 when it was formed, there were 11 people on it: the Resident Commissioner, Administrator, five Company nominees and four elected members by the settlers: 1908 the settlers achieved a majority of 7 to 5. By 1914, the majority was increased to 12 to 6 and in 1923, it was responsible government. One might add that in 1965, it was independence - UDI! The company certainly worked under the assumption that the settlers would be easier to handle than the Colonial Office with regard to economic expansion.

When the Order-in-Council approving the Commission findings was promulgated in 1920, though modified extensively from a recommended Native Reserves cut of 2.7 million acres to 1 million, the Company and the settlers joined hands to celebrate. The Africans were pushed further from the markets and the railways and roads. The great squeeze on the African peasantry had intensified. This time, international capital had received the backing of the Imperial government to embark on its proletarianisation and termination of the subsistence farming class. True to form, the agents of international capital like the chairman of the Commission, Coryndon, (described as "a company man by personal experience and sympathy", (Dann 1963)) had wrongly perceived: little conflict between whites and blacks; an end to: tribalism,



unproductive farming methods, attachment to tribal land; he had further foreseen a slow population increase and an increase in reserves carrying capacity -

"a bestowing of inestimable benefits of European civilisation to eager African recipients".  
(Palmer, p.124).

One draws the conclusions that although the Imperial Government viewed the problem in the colony differently and indeed tried to protect the African people from extreme exploitation by the Company, its pacifying effort created the conditions for capitalist development. Through its orders in Council and authorising of ordinances, it legitimated - based on wrong advice, exploitative and dehumanising company policies. At different points in the twenty-five years to 1924 of company administration and Colonial Rule, both appealed to the settlers for an alliance, thereby giving them a lot of leverage and power in the running of affairs of the country. In a way it is these appeals in the early days of settlement, for the settler support in their different battles between each other, by the Company and the Crown, which built into the Rhodesian settlers a defiant attitude, pampered by developments in South Africa : which gathered momentum over the decades and culminated in UDI in 1965.

In 1923 a referendum was held in which the settlers opted for Responsible Government as opposed to joining the Union as a fifth province. Accordingly Southern Rhodesia

was annexed by the Crown and a Governor appointed.

(iii) THE PROCESS OF CLASS FORMATION AND ORIGINS AND GROWTH  
OF CONFLICT IN RHODESIA

".. I think to be slaves of the State ... is the best thing for the development of the black races of Rhodesia",

Rhodesian Mine Owner in evidence to the South African Native Affairs Commission 1903-1905 (Onslen p.74)

(a) Race In Class Formation and Conflict

The literature on class formation in Rhodesia highlights one most peculiar feature to this country which only South Africa matches it on - ie racial differentiation. This becomes understandable when one observes that, although the majority of the people who entered Rhodesia were English speaking, they had lived many years in South Africa. George Kay writes that, Rhodesia's heritage from it in terms of persons and influences is therefore very substantial and is probably greater than that from Britain. The earlier weaknesses in ties between the two and certainly the refusal to join the Union in 1923, are attributable to English-Afrikaaner supremanist differences. The conflict between the Boers and the British Government affected the relations between the people of these backgrounds.

The Afrikaaner population that came to Rhodesia did so with the intention to settle, having been squeezed out of the Transvaal, Natal or the Cape. The one common feature between him and the English speaking settler was that the



two held a 'general derogatory view of the African society in the late 19th Century'. It has been asserted that:

"the bonds of ... a common viewpoint, as regards Africans, have given Europeans in Rhodesia a remarkable solidarity, which minimizes differences in nationality, culture and class". Kay (1972).

Bryce noted that:

"the sense of superior intelligence and will, produce in the European, a sort of tyrannous spirit .... the tendency to race enmity lies very deep in human nature".

Here was a search to justify this racialistic attitude on the grounds of creation and nature. Some religions - the Dutch Reformed Church, actually quoted from the bible the claim that the whites were superior by will of God! Hone (1909) shows how this influenced the BSA Company and how subsequent national investment attitudes were moulded on the grounds that:

".. differences in character, temperament, intellect and human life itself are so well marked ... that never will it be possible for the two to blend and amalgamate into one ... it must .. be recognised that in industry, commerce, manual and domestic labour, white and black races will be indispensable to each other, the former as employers, the latter as labourers".

From the beginning therefore, the real basis of the differentiation which became the cornerstone of white ideology was the assumed relationship of each race to

the mode of production. The role of political factors based on race in determining the access to economic means was therefore paramount in the Rhodesian class formation pattern. This is unlike normal patterns where the material base is the main determinant. Of course this is not to rule out the existence of a strong white material base in the form of Rhodes' investment through the Company and individual settlers' own contribution. The political dominance determined the climate within which interaction was to occur between the whites and the Africans.

(b) DIFFERENTIATION IN PRECAPITALIST SOCIETY AND THE PLACE OF RELIGION

The above summary views of the pattern of class formation based on race though true, hides class distinctions which require a closer examination, if a case is to be made for our claim that class based differential access to services such as health and education does exist. It is easy to be tempted to conclude that class is a foreign ideology alien to the pre-colonial African society. Our discussions have however disclosed some indications to the contrary (Chapter I, p.3.). Some of the disclosures tend to confirm assertions and writings by others that:

"pre-colonial African socio-economic and political developments favoured and in fact influenced, the kind of government that colonialism instituted".  
Lenneiye 1980 p.57<sup>1</sup>.

The discussion in Chapter I, p.3-5, brought out that the Ndebele held some chiefs in vassal state who had to pay tribute in grain and livestock. Throughout the Ndebele march into Western Zimbabwe, those tribes who fell under their military aggression, were absorbed into the tribe but at a lower strata.<sup>2</sup> Two of these absorbees were distinguished (Kay, 1972) - see Chapter I p.5, as the Enhla, who were absorbed from Northern Transvaal and the Holi - the serf-caste, who were the latest from the defeated Shona chiefdoms. The original Nguni stock constituted the Zansi - who occupied the highest social strata. Within this stratification was further differentiation based on status which distinguished the Royal Family, the indunas, the fighters, the agriculturalists, the traders and the medicine men and midwives. Jones (1953) writes that the Holi had to hoe in the King's fields before they were allowed to start on their own!

It is interesting however to view the impact of western

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1. Lenneiye, M.N. 1980 "Health and Rural Development in Kenya: An Analysis of Health Services Availability and Utilization within the Framework of Class Formation In Rural Areas". Ph.D Thesis, University of Bradford.
  2. A broadly similar though perhaps less distinct classification existed for the Shona round about the same period. See Chapter I p.



civilization especially with regard to how the above groups resisted and reacted. The medicinemen, herbalists or spiritual mediums had a lot of influence and will be an important focal point in the study. They posed the longest lasting challenge to the colonial onslaught and the missionary effort. Despite Mzilikazi having granted Moffat the permission to build a Mission Station as early as 1859, their attempts at converting the people were in vain. Ancestral worship was too deep rooted in the culture of the African in both Matebeleland and Mashonaland. Its conception of disease as a family issue rather than one person's ailment posed a divergent view (which was a cause for more social cohesion so that the ancestral spirits wouldn't bring evil to the family) to that expressed by Western curative medicine which treated the person's illness but did not minister to the psychological stress resultant. The one sought a cause in the social environment while applying herbs to the ailment to restore physical balance, while the other just proceeded to restore the physical imbalance not taking account of the resultant mental stress. Ancestral worship dated too far back to be driven aside by missionary religious ministering per se. As Mbiti (1969) observes:

"Africans are notoriously religious and each people has its own religious system with a set of beliefs and practices. Religion permeates into all the departments of life so fully that it is not easy or possible to isolate it ...".

Just as the treatment of disease and sickness was

inseparable from ancestral worship, so too did the missionary realise the limitations of his efforts in attempting to convert the Africans. This was what motivated missionaries to actively encourage settlerism in Zimbabwe and elsewhere in East Africa. Christianity and traditional social ties could not be practised together because of their contradictions. Missionaires therefore needed more backing to challenge the other institutions and take over from them the variety of aspects including education and social control. To succeed, missionaries had to show more power so as to extract the people's confidence in their ability to protect them if they abandoned the ancestral worship and stopped getting treatment from the medicine men.<sup>1</sup>

In a bid to encourage more settlers so as to present the cultural alternative, the missionary Thomas, between 1859-70 wrote glowing reports of crop farming by the natives and Moffat wrote on the availability of land for 'myriads of white people .. without displacing a

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1. Oliver, 1952 (Quoted in Lenneiye, 1980) p.210 writes that: "both medical and educational work came to be viewed, no longer as rather dubious auxiliaries of evangelism, but as means of consolidating Christian life among the baptized". In the integration of medicine with missionary work, the skills in medicine and science in general raised the missionary to the level of a magician and earned him prestige among the people. Since they could better cure some diseases than the medicine man or the traditional midwife, they got considerable power over Africans. If one adds the social and economic mobility that accompanied undertaking their education, they were soon overwhelmingly powerful even for the state machine to ignore. Coupled with their landholding, they constituted an Upper Class, a powerful force.



single native'. In other quarters, they gave encouragement and provided the moral justification for colonialism; as when the Bishop Knight-Bruce stated that:

"... land which they (the Shona) have never occupied may with justice be said not to belong to them".  
(Quoted in Chapter I p. )

The relevance of the above can be understood in the context of the missionary role in colonialism. Studies (Lenneiye, 1980) in East Africa showed interestingly that the questions of social 'power', in the form of control over the people's hearts and minds, serves to explain the behaviour pattern of Christian penetration in Africa as a precursor to colonialism but heavily dependent on colonialism setting-up Administrative structures. From the very beginning therefore, the seeming limited struggle for control of native minds between medicine men and missionaries was a wider and more determined struggle between retention of the African institutions and their accompanying power strata; and the missionary with his alien values and accompanying institutions backed and aided by colonial administration and financing. It was no accident therefore that missionaries set up health posts adjacent to churches and established schools and vocational training financially aided by government. Groves in 1955 observes in East Africa that the Imperial East Africa Company, invited the churches to



establish stations and even encouraged financial support for them, because they taught skills which the Company needed to open up the country to investors and for Administration (Lennieye, 1980). As we shall see in later sections, the missionaries played a central and crucial role in class formation, for: those who got converted came and lived on their farms (after the Native Reserves Act) and thereby escaped the proletarianisation that followed crowding into reserves; those who got educated in their schools and training centres acquired social mobility which pulled them out of the proletariat category into an elite class with its own interests.

Palmer observes that in the 1923 referendum, it was their persuasion which influenced the pressure groups in Britain to back self-rule just as their influence made the limited number of African elites throw their lot in its favour. The strength of missionary persuasion, though often exaggerated, was held responsible by the African associations and later nationalist organisations for pacifying, dulling and taming the African spirit of rebellion and revolt against massive exploitation and white domination. Its call for the people 'not to seek material and worldly comforts' was accused of drawing the African mind from the serious issues of material poverty while the whites lived in over abundance out of African labour. It is however ironic that the leading Nationalists and opponents of the white

government were products of missionary education; just as the emergent groups of African elites after self-rule in 1922, who preached the politics of participation were also their earlier products.

The role of the Missionaries both in the sowing of the seeds of conflict and in its final resolution ten decades later, is prominent because it straddled all aspects of life. It is true that their explorations were primarily for Christianity but their findings were used by the governments to make the first colonies; in the same way, they rode on colonial administration's backs to spread Christianity. Lenneiye in the East African context observed that:

"Missionary needs, imperial trading companies and colonial bureaucracy all had a stake in colonial expansion."<sup>1</sup>

In this complex chain of interests were to be interwoven African needs and it became progressively difficult to demarcate the boundaries of theology, trade and administrative problems in the expansion of capitalism. The defence of the institutions of colonialism became necessary if missions were to continue to retain the privileges bestowed on them by the Company Administration.<sup>2</sup>

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1. Lenneiye, M.N. Ibid p.106.

2. It is postulated here that the practice whereby ministers of religion, as government responsibility patients, and their families have free health care in government hospitals was a 'quid pro quo' for the missionary contribution in the early days



At the same time, it was in the interests of Christianity that some of the harsher colonial government measures, 'the ugly face of capitalism', were opposed by missionaries. In the end they harmonised the conflict between labour and capital, and in that manner reformed colonialism. Their longest standing achievements were in health services and education. It is also here that their victory over pre-colonial African institutions was sealed. Through associating the use of modern health services, (curative only), with being Christian; they accelerated the breaking down of the equilibrium with nature among the indigenous population without providing enough health posts to cover all populations. Although this aspect is mentioned here it will come out in later discussions. The role of missionaries needs to be put in its proper context if the discussions on the process of class formation and growth of conflict are to be understood.

(c) Peasantization, Proletarianization and Conflict

The period following the end of the Chimurenga Wars in 1897 saw the entrenchment of colonialism. British rule was established through the direct appointment of the Resident Commissioner who had the power to approve the Ordinances passed by the Legislative Council (Leg.Co.) and the appointment of Native Commissioners (NCs) to take charge over the administration of Native Reserves. These were set out to accommodate the defeated and now demoralised African population. The British view



regarding the Reserves was that they were temporary. The natives had to be monitored to ensure that there was no further uprising. With the expansion of capitalist development, they would be absorbed as workers in mines, farms and industry as happened in Europe. This coincided with the interests of capital. On their part, the Africans resorted to agriculture as a means of maintaining their freedom from working under the whiteman. As long as the Reserves enabled them to farm and produce a surplus to pay for the taxes, they did not need to work. Since the European agriculture was not yet established, the period immediately after the wars was a boom for the African agriculturalists who supplied the small mine workings. This was possible because the movement into the Reserves was not fully enforced so land was still fairly adequate for those who moved. This was soon to end however to be followed by full peasantisation and proletarianisation.

The BSA Company's authority was very much reduced following the Wars. It however was represented on the Leg Co by five nominees. In a bid to curb the power of the Crown, it supported the election of representation to this body by the settlers. In 1899 therefore, the settlers had four elected members sitting on the Leg Co. This number was increased to seven and by 1914 the settlers had a majority of twelve! This meant that the settlers had a major say in the affairs of the state while African interests remained the preserve of the Crown. The interests of international capital as

represented by the Company and those of the settlers, coincided. They were basically to exploit the country's wealth and promote capitalist economic development which would raise the values of their assets whether they be farmland, mine holdings or the railway network. This explains their hostility towards the movement of the African population to areas they considered good agricultural land on the high and middleveld. Consequently the Native Reserves were sited on unsuitable lands for cultivation as observed in the previous section. Riddell (1978) p.7 writes that:

"... soon the fundamental role of the Reserves was seen to be the provision of a permanent supply of cheap labour for the rest of the economy".

If Laclau's requisite conditions of capitalist growth were to be met, labour had to freely sell its labour power. This was not forthcoming in the years following the Risings. It could only come if reserve farming was at or below subsistence level, if the people were forced off the farms they rented as tenants and filled the reserves to a level of non-productivity. It followed therefore that pressures were put on the Crown to action the movement of people into reserves. Dispersed populations were moved into the created Reserves, a mode of life alien to them and by 1976, Riddell, (1978 p.7) notes that 80 per cent of Matabeleland population lived in the Reserves when in 1909 the total country proportion was a mere 54 per cent (Arrighi 1970).



The process of African peasantisation was therefore given official sanction and embarked on in earnest. This however was not a smooth operation for views differed among the settlers and the Company.

Van Onslen, C. <sup>1</sup>(1976) writes that at the turn of the century the Mining Industry had serious problems ranging from; its own functioning, the economic conditions in the country and the industry's situation within the regional economic system of Southern Africa. The net result was that the working conditions in the individual and Company mining holdings, including the cash wages; 'were incapable of attracting labour'. To get to the profitability badly wanted (especially by the Company whose shares value had tumbled on the London Stock Exchange) the industry had to curtail indirect expenses. This meant worsening working conditions. Its cash wages could not compete with those offered on the South African mines although they were better than in 'agriculture and plantations including those in the Northern territories of Zambia and Malawi. They could not therefore attract local labour since its agricultural surplus enabled it to have a separate cash income. The local African population in Rhodesia did not seek to sell its labour power freely where no inducements existed! In the face of this situation and the Company's

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1. Van Ouslen, C. (1976) "Chibaro: African Mine Labour in Southern Rhodesia 1900-1933". Pluto Press Ltd. p.74.



desperation to promote investment by demonstrating good output and profits; 'wages in Rhodesian mines were forced up between 1898 and 1903' (Arrighi 1970).

This hit the Company badly and worst-off was the individual mine owner. Even the farmers who were struggling to make a start were badly affected. Methods of procuring labour at a low cost (to start with) had to be devised and then wages had to be reduced! Since the market forces had worked to their detriment, these groups resorted to the political weapon, for did they not hold state power? Through their representation on the Leg Co they started to pressure the Crown to accept legislation compelling the Africans to work on the mines, farms and construction work. The forces for African proletarianisation by force had gathered momentum. Three views were prevalent regarding how to proceed. The one group, which had the support of international capital, was in favour of a residual labour pool. It preferred 'a stabilised African labour force resident on the farms and mines with their wives and children thereby ensuring labour reproduction'. This was the 'Proletarian school' which was anti-reserves.<sup>1</sup> The 'migrant school' wanted young men with rural roots to extract labour from when needed and send back to the Reserves when unwanted. That was the one consistent with settler ideology for it ensured that

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1. Van Onselen, C. 1976 p.76.

they bore no responsibility over labour's welfare - it drew from South Africa's Glen Grey Act. The others including the landowners, pressed for legislation supplemented with increased taxation to force local labour on to the market at a cheap rate. (See Table 3:2

Although the British Government did not go all the way along the settler demands, it conceded on legislation. The Masters and Servants Act, Pass Laws, Native Regulations Ordinance and the Compound system were enforced. Hut tax, dog tax and cattle dipping fees were enforced. This was all accompanied by enforcement of movement to the Reserves which became over crowded. The surplus which the peasants used to produce was gone and no cash income to meet the taxation was forthcoming except through working on mines and farms. The Labour Board of Southern Rhodesia on the other hand was busy recruiting contract labour, a practice called 'Chibaro' (See Chapter I above, p.8). To ensure that no local labour went in search of better wages to the South African mines, enforcement of Pass Laws requiring permits to be at any place (for African males) was undertaken which included border checks! In Mashonaland, NCs and their 'messengers', forced Africans to undertake work in the mining industry.<sup>1</sup> To ensure that there were no

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1. Van Ouslen, C. "The Role of Collaborators in the Rhodesian Mining Industry, 1900-1912", African Affairs, Vol 72, No.289, 1973 p.410-11



deserteers, the Chief Native Commissioner authorised Government 'native police' to live on compounds. Through this process, the NCs were able to send 2900 workers to the mines in 1901. Table 4.1 shows the growth of labour in the mines. Despite these efforts, local labour still provided less than thirty per cent of annual industry requirements by 1910. The number of desertions remained high so that the average period of service was only six months in 1912. The industry therefore continued to require immigrant labour from neighbouring countries. Because of the low profit level mineowners continued to provide bad working conditions and the health situation in the compounds was so poor that Administrators from these countries threatened to withdraw their people.<sup>1</sup> The question of the health conditions in the mining and agricultural compounds will be examined under the section on growth of the health services.

'With the destruction of peasant agricultural production came the promotion of commercial agriculture to supply the expanding economy. International capital turned its attention to this sector with the provision of credit

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1. Van Onselen, C. 1976 p.65. In 1909 Nyasaland planters held the biggest ever settler meeting in the colony demanding that all recruiting for Southern Rhodesia be stopped. By 1912-13 settlers in Northern Rhodesia were involved in similar exercise to pressure labour flow which they also needed. Disease in the Compounds provided a good excuse for legislative intervention.



facilities being made available from the Land Bank. European produce was given preference on the internal market as well as in export. African agricultural produce was under priced and charges imposed on inputs which made it unprofitable to sell produce. The advent of colonialism and the forces of proletarianisation which it set in motion brought new structures to the old communal traditions both culturally and economically. It raised the risks to life for both the old and the young. The pressures for land increased, a greater demand for cash to meet state requirements arose and a new value system based on individualism was imposed. The process of proletarianisation was fully underway and with it the vicious circle of poverty was closing. The old and children began to be drawn into the labour system by the sheer need to survive. Van Onselen (p.125) notes that one mine in 1910 was fully staffed by child labour. The implications of all these factors on health are frightening. The fall in living standards, in the social structure amounted to an unprecedented state of underdevelopment for the African population. Within three decades, the mining industry could state that:

"On the whole, native labour is cheap, plentiful and satisfactory, and causes very little trouble",

(Onselen 1976) in deep contrast to the situation in 1896. (See Chapter I p.12) Clearly the state played a direct and prominent role in the proletarianisation of the peasantry essentially because it was controlled by the

interests of international capital and the settlers. This reflected their class power based on state laws, government protection and financing. The same state created the peasantry, at the same time that the proletariat was formed ie during the transition from the pre-capitalist to the 'colonial racial capitalist economic' forms of production (Adhiambo 1977).

(iv) Growth of Classes and Conflict

It was the desire to recover the heavy initial capital outlay in mine claims, landholding and the infrastructure (especially the railways) which induced the BSA Company to foster the formation of a white rural bourgeoisie and to promote increased white settlement. As the graph 3.3 on p shows, the white population had doubled by 1911 at 23000. The upward trend continued steadily in the period between the wars but jumped after the Second World War and following the formation of the Central African Federation in 1953. This increase in population required an extensive expansion of agriculture and commerce. Thus 'a process which led to class structures was started which crystallized in the 1930's. (Arrighi 1973).

The white rural bourgeoisie was made of owner workers of small to medium sized mines and farmers committed to developing the country. They therefore assumed a national character whose interests would soon conflict with those of international capital whose concern is



World  
Population  
'000

(millions)

1950

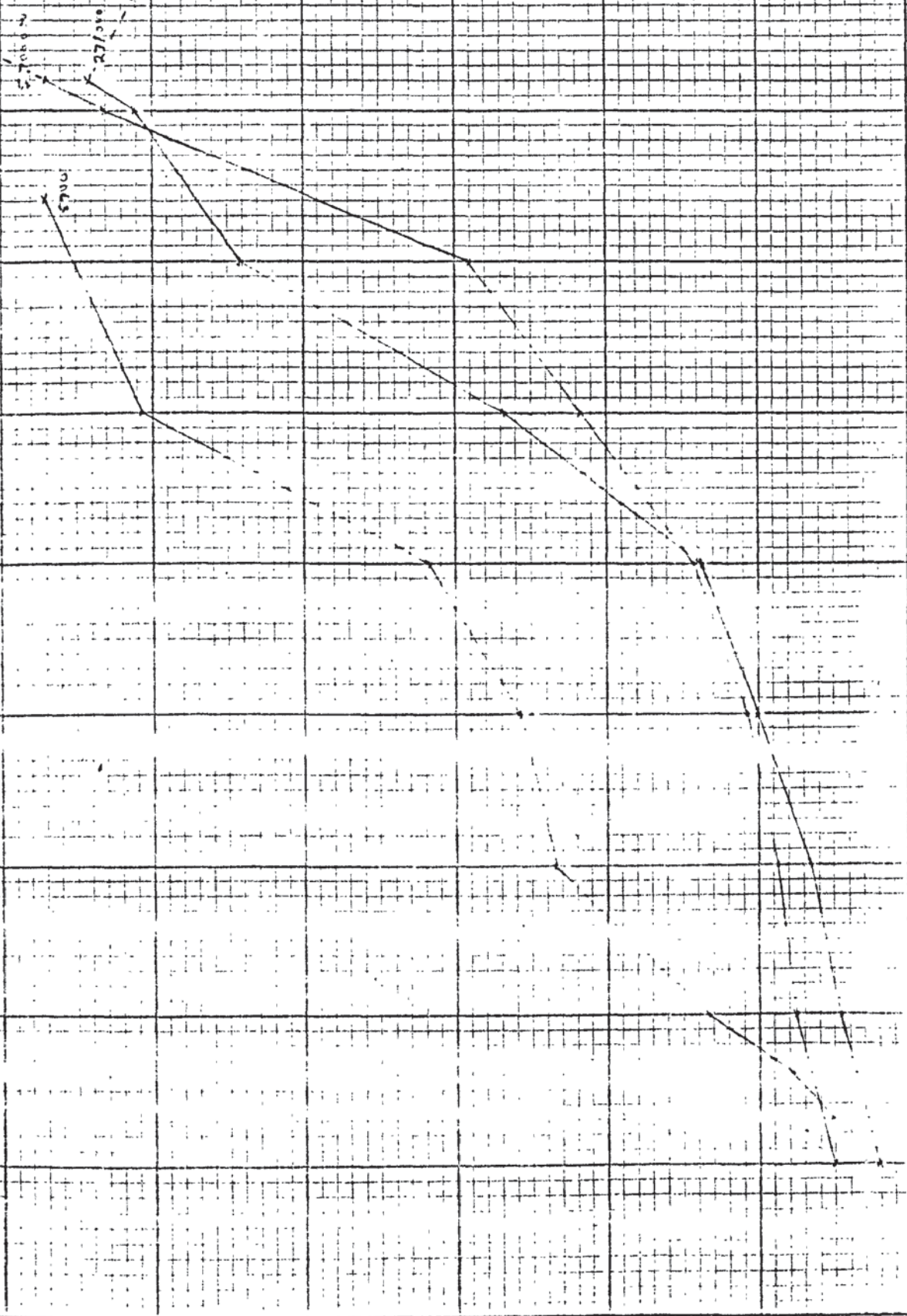
1960

1970

1980

1990

# THE CHANGES IN EUROPEAN POPULATION, EUROPEAN FARMERS AND THE AFRICAN POPULATION.



Source: P.A.S. (1990) p. 12 and 13



extraction and exploitation of wealth. Arrighi states that in the inter-war years, one-third of the Europeans gainfully occupied belonged to the rural bourgeoisie and would be agriculturalists included civil servants, business and professional men, miner or railway employees who looked forward to retiring to a plot of land. This pattern of settlement made Rhodesia unique. Initially the Company represented International capital with investments in railways, mines and land but soon other companies and syndicates joined in commerce and industrial manufacture. The net result was keen competition for white personnel between commerce, the national bourgeoisie and government services. Since there were no skilled Africans, this drew a third class of settlers into Rhodesia, the skilled and professional class who formed the petty bourgeoisie. The last group of settlers were the wage earners - artisans, semi-skilled, clerical, foremen and administrative employees whose demand grew with the expansion of all sectors. Arrighi observes that the pattern of settlement unlike in South Africa or Algeria was a consequence of and did not precede, capitalist development in the country. Capitalist development had occurred in the first quarter of the century with the peasantisation and proletarianisation of the African population - through the process of their under-development by the international capital, national bourgeoisie and the colonial administration.

The fact that all skilled and semi-skilled labour had to

be imported, coupled with the settler view of the African, led to the development and entrenchment of the 'no-poor whiteism' ideology. The Africans as we viewed above, formed the wage workers and peasant group who were forced by legislation to retain rural links in the unsuitable and unproductive reserves. An insignificant number of them fell into the middle class and petty bourgeoisie classes through land purchase in the Native Purchase Areas<sup>1</sup> and education in the missionary schools. Discussion of this class (the African workers, peasants and elite class) will be in relation to the other classes and on the issues of conflict.

The white rural bourgeoisie's power base lay in the land both as a means of production and through its appreciation in value on the market. Their interests lay in expanding their production so as to engender economic development which would attract white settlement and investment. In this they had obtained the backing of the Company and of legislative measures which forced the African agriculturalists out of competition thereby providing them with cheap labour,

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1. Riddell, R.C. 1978 "The Land Problem in Rhodesia: Alternatives for the future". p.8 stated that under the 1930 Land Apportionment Act, 7.5m acres were allocated for Native Purchase of which 4m acres were unsuitable for farming. Moreover only those who could afford to pay for them moved in most of whom were from urban employment. By 1977, the NPA had been cut by half and only 8102 farms were occupied.



an internal market and the potential of the export market. What they needed were complementary sectors which would increase the demand of agricultural produce and this required over-head capital which could only be brought by external investment. In so far as they wanted to attract investment, by showing potential for return because labour costs were low and a good infrastructure existed, a coincidence of interests with international capital existed. The later, as we saw, were keen to recover their initial investment. There was however the danger that too rapid a growth of the national bourgeoisie through industrialisation could have endangered labour supply. A need to accelerate labour flow became urgent, hence the enforcement of provisions of the Land Apportionment Act of 1930 and the Maize Control Acts. These had a dual function of ensuring, in addition to labour, that land was available for European use and that African agricultural produce was under priced so as to make way for and subsidise European produce. To facilitate European produce marketing, the Tobacco and Dairy Control Boards were set up and a Land Bank created to provide credit facilities to hard pressed farmers.<sup>1</sup>

Whereas the national bourgeoisie's interest in overhead

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1. Palmer, R. 1977 p.211 observes that the Depression had hit the farmers badly.



capital lay in its ability to induce greater demand for agricultural production, international capital had interest in restrictive policies only increasing investment in response to demand. White wage workers on the other hand provided a market for the national bourgeoisie in addition to their expanding the white settler group. They benefitted from the scarcity of skilled labour which had to be imported and therefore earned high salaries. Their interests lay in continued lack of skilled local labour and unavailability of education and training facilities for Africans. Herein lay their conflict with the interests of international capital which was opposed to high wages and labour importation costs. International capitalism stood to benefit from low training costs of the African populations and was opposed to economic concessions to this class which had a strong bargaining position. The coincidence of interest between the skilled, professional, semi-skilled and artisan classes and the national bourgeoisie in: the industrialisation of the country, the limitation of actual and potential African competition, and the growth of the domestic market; led to a natural alliance between them - against international capital and the African classes.<sup>1</sup>

The interests of the African peasantry, proletarian and

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1. Arrighi, G. (1967) "The Political Economy of Rhodesia" The Hague, p.33-34.

and the petty bourgeoisie lay in being drawn into the money economy because of the increasing productivity in that sector. Their education and training would have increased their bargaining power for high wages, it would have further limited racial competition which led to differentials in wage payments and living standards. Since the petty bourgeoisie in agriculture also employed labour, their interests were in direct conflict with the white rural bourgeoisie. It is noticeable that a coincidence of interests between the majority of the African workers and international capital existed in racial competition for skilled jobs. The potential for an unholy alliance between these two therefore existed to confront the white classes. Clearly an uneasy stage for conflict was set, what factors then interplayed in the struggle which followed to bring about the white classes dominance?

Again because the interests of international capitalism lie in extraction and appropriation of surplus, it shifts its alliances to suit that sole purpose.

Arrighi (1967) writes that the key to understanding the outcome of the political struggle lay in understanding the different degrees of class consciousness (awareness of their own interests by classes). The period after the First World War was characterised by skilled labour shortages and world demand for raw materials increased which had the net effect of increasing the power of the white skilled and wages workers and the national bourgeoisie. This was further boosted by the granting



of Responsible Government, a move opposed by international capitalism in favour of Union with South Africa which would have expanded and strengthened its interests. This gave the national white classes sizeable political power which they went on to strengthen through class coalition. When the Depression came the whites were very conscious. The wage classes backed the white rural bourgeoisie in return for political and economic concessions including the Industrial Conciliation Act - which prohibited Africans from competing for 'white' jobs - and the prevention of the flow of unskilled 'poor' white labour from Pretoria.<sup>1</sup> They became Unionised.

Armed with greater political power and class coherence, the whites' concern now centred on preserving and entrenching it at all costs. It is the size of economic dependence on international capital<sup>2</sup> which conclusively led to the development of moderate or compromise policies which the State introduced from this point. This explains the exercise of legislative power to set up an institutional framework strongly biased in favour of the interests of the white national

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1. Arrighi, G. (1967) p.34.

2. Arrighi, G. (1967) p.20 states that the BSA Company controlled the railways, the bulk of gold production and coal mining, land for production of maize, citrus, etc. Other syndicates and Companies dominated Asbestos and Chrome Mining, also tobacco production and cattle ranching.



classes vis-a-vis the African classes. The legislation which followed was aimed at increasing government intervention in directing investment and economic development so as to promote the interests of the national bourgeoisie and the white workers. Arrighi writes that the period of the 1930's and 1940's saw the founding of several state enterprises including the Electricity Supply Commission, Rhodesia Iron and Steel Corporation (RISCO), Cotton Industry Board and Marketing Boards (see above). These were aimed at easing the international capitalist grip of the economy and reducing overall dependency. Legislation regarding further regulation of labour supply, racial segregation and peasant production and competition has already been noted. This was the situation when World War II broke out. International Capitalism seemed to have been significantly emasculated, but, as Marx observed (Chapter II, p. ) capitalism is inherently dynamic, it transforms itself as conditions change and in the process influences the pace of change within the nation. Before analysing the post War situation however, it is important to briefly view the African response to these repressive measures and the under-developmental forces unleashed on it by both endogenous and exogenous capital.

Bradby (1977) explains that military victory does not have to be a pre-requisite for the implantations of the capitalist mode of production, but the case of

Southern Rhodesia shows that it certainly speeded up the process. In Table 3.2 I show how the charges for hut taxes were imposed and increased over time following upon the colonisation of the country after suppression of the Risings. It is shown in Table 3.3 and 3.4 how the low wage levels coupled with land expropriation all increased the squeeze on the African population forcing some reaction.

TABLE 3.2:

AFRICAN HUT TAX RECEIPTS

YEAR	AMOUNT \$	% INCREASE (over Period included in table above it)
1897-8	35 638	-
1898-9	73 122	105.2
1901-2	92 415	26.4
1904-5	176 538	91.0
1909-10	200 000	13.3
1925-26	300 000	50.0
1937-38	400 000	33.3

Source: Palmer (1977), p.79

Note: Population growth rate (calculated on the basis of African males over fourteen) remained constant at 1.6% per year between 1906 and 1936, rising to 2.7% in the period 1936-1946 and then up to 3.4% between 1946 and 1956. (See Graph)

It can be concluded therefore that even allowing for new paying males, the increased amounts indicate raising of levies per head.



TABLE 3.3

AFRICAN MONEY WAGES AND COST OF LIVING INDEX FOR SELECTED YEARS

YEAR	AVERAGE WAGES			COST OF LIVING INDEX		
	MINING			AGRICULTURE	EUROPEAN COST OF LIVING: FOOD, FUEL AND LIGHT	AFRICAN IMPORTS PRICE INDEX
	NUMBER EMPLOYED	INCLUDING RATIONS	EXCLUDING RATIONS	INCLUDING RATIONS	(1914 = 100%)	
1904	-	46s 9d	39s	-	-	148
1911	37909	-	(32s)	-	-	94
1914	36100	-	(28s)	-	100	100
1922	35718	45s	(28s)	20s	114	195
1926	41617	-	-	21s 8d	109	(168)
1932	36068	-	25s 10d	-	94	-
1938	-	32s 6d	23s 10d	-	93	-
1939	-	34s	24s 11d	-	94	-
1943	-	42s	27s 5d	-	112	-

Source: Arrighi, G. and Saul, J.S.

"LABOUR SUPPLIES IN HISTORICAL PERSPECTIVE: A STUDY OF THE PROLETARIANIZATION OF THE AFRICAN PEASANTRY IN RHODESIA",  
ESSAYS ON THE POLITICAL ECONOMY OF AFRICA, 1973, p.190

Note: The Table was compiled from various sources. Commodities in the index are those purchased by Africans for which quantities (physical) were available - biscuits, coffee, rice, fish, sugar, candles, soap, books, matches, shoes, hoes, etc.  
Weights in the index calculation are based on the value of imports which includes European consumption. This however still enables us to make the points we want to make.

TABLE 3.4

PERCENTAGE OF AFRICANS ON RESERVES; SIZES OF  
EUROPEAN LAND AND UNALIENATED LAND IN 1915

LAND CATEGORY	SIZE IN ACRES ( Millions)	% OF AFRICAN POPULATION LIVING ON IT	% OF AFRICAN POPULATION ON EUROPEAN LAND
MASHONALAND	- } 20.5	65	35
MATABELELAND	-	36	64
EUROPEAN	22.4	-	-
UNALIENATED	47.8	-	-

Source: PALMER, R. (1977), p.88

Note: The Imperial power was in favour of retaining adequate reserves, as a sanctuary for those being evicted from European farms, and in protection of tribal society. The B.S.A. Company, as would be expected, took the view shared by the Native Reserves Commission (1914), that they were for the natives who could not be assimilated into labour. The Company envisaged disintegration of tribal society in the face of expanding European civilisation and foresaw an expanding role for Africans in a de-segregated economy. The settlers wanted reduction of Reserves-land available and wanted all Africans not enrolled as labour to be put in these Reserves from which labour would be cheaply drawn when wanted and dumped when used-up. (Riddell, 1978, pp.36&37)

TABLE 3.5

THE DIVISION OF LAND IN RHODESIA BY RACE

LAND USE	AFRICAN AREA	% TOTAL AFRICAN AREA	EUROPEAN AREA (ACREAGE)	% TOTAL EUROPEAN AREA	NATURAL (ACREAGE)
FOREST AREA	424840	0.9	1863918	4.2	-
PARKS AND WILD LIFE	630526	1.4	4383447	9.8	-
TRIBAL TRUST LAND	39979963	88.9	-	-	-
PURCHASE AREA, AFRICAN	3670770	8.2	-	-	-
GENERAL LAND	-	-	38564496	86.0	-
SPECIAL DESIGNATED LAND	291660	0.6	18910	-	-
NATIONAL LAND	-	-	-	-	6596876
TOTAL (96425840 = 100%)	44997731	46.7	44831233	46.5	6.8

Source: THE LAND TENURE ACT (1970), Chapter 148, pp. 204-309



Though not sufficiently reliable, the above statistics (Table 3.3) give an indication of the direction of change of real wages and a rough assessment of the comparative magnitude. It is noticeable that:

- (1) African real wages decreased rapidly in the periods 1904-1922.
- (2) A moderate increase in Agriculture 1922-1926 and in Mining 1938-43
- (3) Constant real wages in 1932-39.

These figures attempt to throw light on the rate of African participation in the labour market by relating the number of African males (indigenous) in wage employment to the total over fourteen male African population at any given time. This suggests that conditions affecting indigenous labour supply shifted in favour of greater responsiveness to employment, continuously. Arrighi (1973) observes that while 'before 1922 the participation in the labour market did not increase in periods of falling wages (as a sign of response to the market forces), after that year; it always increased irrespective of whether real wages were falling, rising or remaining constant. Other stronger forces were interplaying and the historical analysis made, points strongly to the role of political changes in favour of national and international capitalism. Giovanni Arrighi (1973) seeks explanation of this labour supply trend in economic factors and goes to distinguish between 'necessary' and

'discretionary' material requirements of the society, (the African society) at different points in time before the enforcement of politically engineered legislation. He further writes in "The Political Economy of Rhodesia" 1967, that the Africans lacked class consciousness and that the character of their response was ascribable to political inertia and passiveness. He even quotes Gray (1960) and Van Velsen (1964) in the former's view of the Shona as:

"small and broken tribes, scattered and restricted to their separate and distant reserves .... prevented from developing any cohesion or a wider outlook",

and the latter's view of the early 1920's protest groups as vague and ill-directed, disappearing as soon as they were faced with official repression.

The above greatly underscores the groundswell of African feelings at the different points in time. Vambe (1972) in "An Ill-Fated People", sums up the feelings of the Africans following their military defeat by the imperialist forces in 1897, when he states that,

"as long as they grew food for themselves, they were spared the humiliation of working for whitemen".

This feeling became a legacy for all African generations to come - the ability to provide oneself with food was essential for social and political freedom though

limited. Whether scattered or restricted it persisted and they bid their time making use of all available channels to wrest themselves out of the white imposed snooze. This state of want was rooted on the question of land, therefore any elitist groups who clamoured for participation in the voting system of the 1920's because they had the education and the means, were not speaking for the Africans. Those workers who joined the capitalist sector retained their rural roots, not merely because they were unwelcome to permanently stay at their work places in the mines or towns; but because they hoped one day to settle on their rural plot and farm. Those who earned enough bought farms in the Purchase Areas so they could enjoy their limited freedom for they could not hope to compete with European produce.

Ranger (1970) writes that:

'a variety of voices were making themselves heard, ... no single one of these voices, nor a number of them in combination, was loud enough to command attention or strong enough to be accepted as representative',

at the end of World War I. The crux of the matter lay in the fact that the colonialist forces had just come out of a war short of raw materials and with damaged economies. They depended on international capitalist forces to extract as much surplus as possible to 'build homes fit for heroes' in the mother country. The settler agents of capital meanwhile were busy



'cashing-in' on skilled labour to foster their own economic development and promote white supremacy in Rhodesia independent of regional or imperial control. The question is posed then as to where the Africans should have made themselves heard?

The Africans had seen the Imperial power, the Company and the settler alike dynamite them in the Chimurenga war years, force them into labour, impose Pass Laws, pass ordinances grabbing their land and forcing them into Reserves, and knew that until such a time as they could again challenge the white imperialists by force they were virtually slaves. Other people purported to speak for them in the 1920's like the missionaries and the South African blacks of Christian background like Twala - who were joined by similar elite groups inside Southern Rhodesia. These had sided with the whites for responsible government on the grounds that it was the lesser of the two evils. The Rhodesian Native Association for example advocated the Christian solution and believed that:

"any opportunity for improvement ... is possible only by<sup>1</sup> the presence of the white man in our country".

The Rhodesian Bantu Voters Association also preached

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1. Quoted in Ranger, T.O. 1970 "The African Voice in Southern Rhodesia: 1898-1930" Heineman Ltd. p.105.

the politics of participation - begging to be allowed a say. These elitist groups spoke for themselves and distanced themselves from the working and peasant mass of the people. These expressed themselves through cultural and social movements and groups on mines, in farms and in the towns. Since the rural areas remained the workers base, they had influences there where the land grievances exacerbated by the Land Apportionment Act of 1930 and further Maize Control Acts and Native Registration Acts infuriated them and made them more resilient and determined.

When the Rhodesian Industrial and Commercial Union was formed it had a large following in both rural and cash economy sectors. By the end of the 1920s wages were accounting for 80 per cent of the African cash earnings, so the dependence of Africans on the sale of labour had increased greatly. The ICU by 1929 was making articulated demands for compulsory and undenominational education and parliamentary representation.<sup>1</sup> It was clear in its mind on the role of the church in colonialism and capitalist development. Clearly therefore it antagonised the elite, the State and the Church. In that respect it had articulated the class relations of the social and economic conditions of the African proletariat and peasantry.

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1. Ranger, T.O. 1970 p.152.

Ranger concludes that if the ICU was not the progenitor of an effective trade union movement, it was in some sense the forerunner of the mass political parties of the 1950s. One of its aims was securing more land for the reserves, suitable for cultivation. It organised mass meetings and used posters - a new style of politics for Africans. Palmer (1977) writes that it:

"succeeded in creating a rebellious atmosphere in Reserves ... Natives were displaying definite though passive resistance to orders and in one district they went so far as to boycott the Native Commissioner's office." <sup>1</sup>

Arrighi is therefore incorrect when he asserts that Africans were politically inert and not class-conscious. Given that they lacked representation and were well aware of the consequences of an ill-conceived rebellion, their resistance to settler government was profound.

The government response as we saw was an indication of its view of the threat and the determination 'to preserve and entrench' white domination through legislation - eg Sedition Act, Industrial Conciliation Act etc. Monopsonic Organisations controlled by the State were set up by legislation in a two pronged attack on international capital and the African population. The interests of international capital

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1. Palmer, R. 1977 p.228.



would have moved it to align with the African population, but it didn't and instead joined the powerful governing class of white bourgeoisie and now strong white wage workers. The stage was clearly set for the conflict inevitable in capitalist development: but it was to take some time yet to redress the power balance in military terms, before the dominated class rose in armed confrontation.

Writing on the situation in the 1930s, as opposed to the nineteenth century reports of a vibrant existence in the tribal areas,<sup>1</sup> Palmer (1977,p.13) paints a depressing picture of:

".. widespread stagnation and decay ... with greatly reduced number of crops being grown, an almost complete cessation of inter-African trade, and an increasing cycle of rural poverty, driving more and more people away to the towns. By 1939, virtually all vestiges of African economic independence have been shattered, African cultivators have become tied to a world market over which they have no control and a pattern of underdevelopment has been finally established."

O'Brien's (1975)<sup>2</sup> observation that the process of underdevelopment sinks people into even greater poverty seems to be borne out here.

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1. Kay, G. 1972a As quoted in Chapter I reported that 'life in the tribal areas provided a deep if intermittent satisfaction'.

2. See Chapter II, p.42.

The Second World War was followed by a boom in Southern Rhodesia whose net effect was shifting the centre of gravity within the White Community to the wage earners. The scarcity of their skills meant that they were in a strong bargaining position to force up wages and resist changes to the institutional framework of the 1930s. This framework had guaranteed a 'two-pyramid' ideology, whereby the country was divided into two non-competing racial groups. Only within the pyramids was class distinction possible. The white pyramid was, as we saw above, united by the bond of white supremacy and anti-international capital manoeuvres. The upper class therein had made economic concessions to its working class in return for political power. This remained the case as long as there was unity of interest in the country's economic development and industrialisation. The post war developments were to strain that bond to the limit.

The most significant changes came as a result of the growth of manufacturing industry from 9 per cent of total National Income in the late 1930's to about 15 per cent in the early 1950's and over 18 per cent in the early 1960's.<sup>1</sup> A new class was emerging which challenged the rural capitalist sector. Backed by

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1. Arrighi 1973 p.353. Mining contribution to N.I. fell from 25% in 1938, 10% in the early 50's to about 5% in the early 60's.

foreign overhead capital and its access to increased technology and scale of manufacture, the size of units of production and the mode of production changed. Following this change was the quantity and quality of the labour required. Substitution of artisans by relatively unskilled labour followed and accompanying it, stability of African labour became more important than the large numbers of mobile and migrant labour. In addition, the production of low quality consumer goods increasingly became dependent on the growth of the purchasing power of African peasants and wage workers.

The important developments of import substitution increased European immigration and increases in African wage employment strengthened international capital's hold on the economy. The buying of mineral rights by the government in 1933 and other cited measures had greatly diminished this and so did the 1949 buying of the railway system. Arrighi (1973) writes that the revival of the Industrial and Commercial Workers Union (ICU) in the face of Industrial expansion and increased urbanisation indicated the growth of proletarianisation and class consciousness among the African workers and the peasantry. For international capital, this was a welcome development in the face of increased white worker power. The African workers began to put on pressure for better wages and working conditions, for more investment in industrial training and African education. The growth of competition in employment



TABLE 3.6

CRUDE MEASURES OF FOREIGN PRIVATE CAPITAL STOCK IN ZIMBABWE (1935-79)  
(in millions)

Year	Total Capital Stock	Domestic Capital	Foreign Capital Stock		
			Total	UK	SA
1935	\$35				
1935-39	\$60		\$42-45 \$60		
1945	\$60-80	\$12-26 (20-30%)	\$48-54		
1953			\$200		\$50 (25%:1956)
1963			\$350		\$100
1965				\$200 \$150-200	\$100
1974			\$400 \$550- 600	\$225- 300	\$200
1978-79	\$1845- 2255	\$615	\$1230- 1640	\$717	\$478

Sources: Clarke, 1980, p.32

meant prospects for rationalising wages by employers who hitherto had to pay heavily for white immigrant skilled and semi-skilled personnel. The prospects for a growing African middle-class, formed by international capital and liberal elements like Garfield Todd and Whitehead, meant the break from the two-pyramids or racial segregationist policy to one of racial partnership.<sup>1</sup> In the face of African workers and peasants restlessness, the creation of this African buffer class was an act of political necessity. International capital being what it is, stood to benefit greatly from this and in fact had earlier proceeded to press for the Federation of the Central African States, which was formed in 1953.

The formation of the Federation of Rhodesia and Nyasaland was a triumph for international capital for now it had access to the mineral reserves of Northern Rhodesia and labour pool of Nyasaland using Southern Rhodesia as the launching base. In Table 3.6 is shown the growth of foreign private capital stock in Southern Rhodesia over the years. Clarke 1982<sup>2</sup> observes that domestic capital's share in the economy rose after 1945 from 20-30 per cent then to about 27-33 per cent by 1979. This was in consonance with the growth in

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1. Arrighi, 1973 p.359.

2. Clarke, D.G. 1980 "Foreign Companies and International Investment in Zimbabwe". Mambo Press Gwelo. p.31.

local firms, expansion in domestically-controlled enterprises, rising incomes and savings levels of the white households, support given by the State to non-Transnational Corporations (TNCs) in the different sectors and import substitution stimulus and protection to local industry given under UDI. State policy went further in this period to force local re-investment by companies through exchange controls and diminished outflows. Although the imposition of mandatory sanctions was meant to bring down the Rhodesian Government, it only succeeded in making it industrially strong self-sufficient in many products and less dependent on International Capital. Data available after 1963 showed 'a rising share of South African investments in foreign capital stock'<sup>1</sup>. So UK companies found themselves devolving control over their Rhodesian subsidiaries during the sanctions period to their South African firms. In conclusion Clarke writes that the size of internal capital stock has continued to grow and Zimbabwe has become strongly influenced by international investment policies.

The political developments of relevance to the class formations, class interest and class conflict in the 1950's revolved round growing African class

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1. Ibid p.33. See Appendix for the UK, USA and South African owned companies in the Country.



consciousness and the white change of strategy. The Land Husbandry Act of 1951 in fact acted to cement the African nationalist cause. It brought peasants, proletariats, middle class and the African bourgeoisie together in convergence with the manufacturing and international capital against: the agrarian and petty white bourgeoisie and the white workers. This Act attempted to introduce individual land holdings in the rural areas which were now overcrowded and unable to fill the internal maize market now abandoned for the external tobacco market by white farmers. The African population during the 1950's rose from two to three million (See Graph 3.3 ) thereby wiping the effects of the urban drift. Palmer observes that as a result of land pressures in the rural areas, whose origin we have discussed extensively above, the African grievances here swelled into Nationalism so that

"the rural masses propelled the leaders rather than vice versa"<sup>1</sup>.

The formation in 1955 of the City Youth League and the militant African National Congress in 1957, all

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1. Palmer, R. 1977 p.244. It is this rural political consciousness and opposition to the white rule and white classes which led to the rejection of the Muzorewa elitist alliance with them in 1978. The strength of the rural base literally guaranteed the success of the liberation war when it intensified from 1972-1979. They remain the main focus of change.

signified the exasperation of a people too long burdened with an intolerable load - an inconsiderate white bourgeoisie and working class coalition aided in suppressing them by a powerful state machinery.

Attempts at introducing a liberal administration during the federation were shattered by the victory of the right wing Rhodesia Front in 1962. It came to power on the basis of a promise to return white supremacy. The achievements of increased African education, training of teachers, setting up of a multi-racial University in Salisbury, the establishment of two central hospitals for Africans with training schools for State Registered Nurses in Salisbury and Bulawayo, were all in jeopardy. The break-up of the Federation followed soon after and the African Nationalist party (after National Democratic Party (NDP) was banned in 1962) the Zimbabwe African People's Union (ZAPU) was formed to fight hardened Rhodesia whites. With the independence of Zambia and Malawi, all the anti-African majority rule white elements moved into Rhodesia where they hardened anti-African attitudes. They went further than that and considered Britain as pro-African and therefore decided to Unilaterally declare themselves independent of it in 1965.

The tenor of African politics as led by the missionary educated and aspiring African elites was still for participation, for a say, in the running of the country. A qualitative change occurred in 1963 when



the Zimbabwe African National Union (ZANU) broke off from Zapu and resolved to take over from the settler regime by armed force. It immediately drew a socialist oriented constitution and defined a programme of action, starting with civil disobedience inside, followed by armed confrontation. The party leadership was arrested and the party banned but this strengthened the belief of its founders that negotiating and bargaining with the settlers was a non-starter. The party then devised a strategy whereby Herbert Chitepo, who was in Tanzania, was instructed to organise for the party members to be trained and to infiltrate the country. The battle of Sinoia marked a turning point in the history of Zimbabwe for it saw the relaunching of the Second Chimurenga Wars - a revival of the Risings against the whites. The history of the Zimbabwean war of liberation is in the process of being written, suffice here to mention a few developments which had lasting effects.

First and foremost was the fact that in the face of African resistance and rising political unrest, the government became even more repressive. The Land Tenure Act was passed in 1969 further entrenching division of the country into white areas (rich, large, and fertile and including all Urban Areas) and African Areas (barren, sandy, unproductive and in remote areas). This was to prove a blessing for the liberation forces who made the TTLs their strongholds with the support of 80 per cent of the country's population living there.



This fragmentation however dragged the Africans further into poverty, for the now increased and increasing (at 3.6 per cent per annum) population could not find adequate land to farm. The introduction under the Paterson Commission 1962 recommendations of administrative reorganisation, of community development and strengthening of African Councils authority was aimed at strengthening the white philosophy and ensuring:

"...encouragement of the development and growth of socio-political structures which is compatible with the acculturation process of the indigenous rural system and the incoming technological system of the West".<sup>1</sup>

This was complemented with the formation of a superficial alliance between the white classes and the traditional chiefs, in a bid to alienate the nationalists. A restoration of traditional authority and even representation in the Senate and Council of Chiefs at State level. This inevitably put the Chiefs in a contradictory position of having to implement repulsive and hated government policy and at the same time convey the people's bitter grievances on government policy. This alliance presented one of the many breaches of convention which occurred in Rhodesia for it would have made better sense for the

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1. Southern Rhodesia: "Report of Inquiry into the Organisation and Development of the Southern Rhodesia Public Services", Government Printers, Salisbury, 1962 para.615.

Chiefs (traditional elites) to continue their alliance with the British Government who were still legally responsible for African affairs (Degras 1960's view of feudal-imperialist alliances).<sup>1</sup>

The second development was the sealing of the peasant worker alliance facilitated by the Land Tenure Act<sup>2</sup> which effectively deprived all Africans of urban connections. The result was that the new revolutionising politicians further distanced the Chiefs and their white allies and as champions of African rights, called on Britain to exercise her authority. They skillfully pressured Britain to fulfil its obligations to the African majority on the one hand, and continued to politicise the African masses to take up arms on the other. They articulated the class basis of the masses problems of poverty and suppression so that when phoney proposals like the Pearce Commission of 1972 were put before the masses, they were rejected outright. The African demands were now for total political power so that when the white regime attempted to split the African commitment to majority rule by co-opting a clique of clergy and black stooges and forming a Unity government in 1978, the people refused to relent their support for the liberation forces whom they subsequently voted

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1. Chapter II p.15 examines the nature of alliances.

2. See Table on Subdivisions of land.

into power.

A further development which highlights the machinations of international capital when it was faced with a difficult situation in Zimbabwe, in the face of an escalating liberation war, was the Lusaka accord, which culminated in the Victoria Falls Conference of 1975. International capital had benefitted from UDI, and, as the Birnham Report of 1978 disclosed, clandestine but profitable trade had continued despite sanctions imposed by the United Nations.<sup>1</sup> UK and USA companies had expanded through re-investment inside the country and Holding Companies there devolved control to the South African subsidiaries who traded openly in Rhodesia. The dramatic change came when the escalating war made it difficult for the Companies to extract surplus. This is the one aspect which determines the TNC's policies. No sooner had disruption of the economy begun to bite than the Kissingers and the David Owens started running around in diplomatic shuttles to resolve the political situation in Zimbabwe. As we now know, Zanu's resilience saved the country from a neo-colonial debacle. The proposals by the West guaranteed capitalist interests and only transferred

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1. The United Nations General Assembly Resolution 514(v) on Southern Rhodesia in 1966 imposed mandatory sanctions against Ian Smith's illegal regime in Rhodesia which forbade all trade with it.



the semblance of political power. Zanu rejected them and kicked out its founder leader, a cleric who like the rest of his class sought a neo-colonial solution. This was the stage at which the party started to truly articulate a Socialist ideology under the leadership of Robert Mugabe, now the Prime Minister of Zimbabwe.

At the time of this study, Zanu had clearly established that it was fighting a class war, an ideological war against a fascist regime which herded people into the so-called protected villages which had all the makings of concentration camps.<sup>1</sup> Although the Rhodesia State had far more sophisticated weaponry and access to resources, it was fast losing the war because it did not have the most important resource on its side - the people. It was on that basis that Zanu's victory was assured. In a bid to cut its losses, international capital forced the Western Governments to act more determinedly. It is hard to say when the final collapse of the regime would have come had not the Lancaster House Constitutional Conference of 1979 succeeded, but there is no doubt that it was near.

As is now known, pressures were brought to bear on the

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1. People were forced into these camps so as to starve the guerrillas of food supplies. Conditions were extremely bad ranging from overcrowding to insanitary facilities.

intransigent white settlers by the toll of the war. As in the Risings the young Africans fought with courage and determination with the full support of the aggrieved rural masses. The white towns became besieged and isolated and the white rural bourgeoisie's back was finally broken. The constitutional agreement however gave far too much say to the white population who still had economic control. Following the election victory of Zanu the African majority rule government - a coalition including Zapu, had to chart a delicate course of action with the full knowledge that, as happened in other black African states, capitalist interests could greatly sabotage the economy. Given the destruction caused by the war and the displacement of African populations in the African areas - a crisis situation existed which needed a lot of vision to wriggle out of. At the same time the terms under which the African Government was to be shored by international aid, were such as to ensure the flourishing of international and national bourgeoisie interests. Given that the government lacked both the economic muscle and the administrative experience to go it alone, Prime Minister Mugabe decided to take a reconciliatory attitude based on a full rural development strategy. The need to strengthen the roots of power and the source of development effort was recognised. It remained therefore for sectoral planners to draw up plans that would translate this noble goal into reality. It is at this point that, the relevance of a historical analysis, bringing-out the



process of the systematic dehumanisation that is underdevelopment and what factors played a crucial role in its entrenchment; is of importance.

The ascendancy of an African majority to power though headed by a vanguard party dedicated to creating an egalitarian society does not of itself solve the problems of underdevelopment. True, the power of the white ruling class and wage workers coalition is now ended, but that does not mean the end of class structures. The structure and nature of the economy signifies the continuance of differential access. The fact that the Socialist government was put on top of a capitalist economic structure means that the conflict of interest between the two will persist. Marxian conception of the strength of the material base observes that it sometimes 'determines' or 'conditions' or 'corresponds' to the superstructural factors - ie the political, cultural and ideological factors. The need to transform the base cannot be over emphasised. Meanwhile the incorporation of hitherto excluded Africans with appropriate education, into executive and administrative positions to operate the state machinery, is fast creating a new elite. The dangers of superimposing a new approach on and administering it through old structures are mainly that the change which is sought will not be forthcoming and instead the approach will itself be moulded to suit the structures.<sup>1</sup>

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1. see following page.



The experiences of Tanzania give sufficient evidence of the dangers of a bureaucratic elite emerging under the guise of socialist orientation through old colonial structures.<sup>2</sup> The questions of planning and management of sectors to ensure the meeting of the government objectives will be the subject of later chapters.

### CONCLUSION

The policy of divide and rule, devised in the aftermath of the 'Risings' was perfected over the years and continued. In the last decade of settler rule, it took the form of shifting alliances to meet the demands of the fast changing scene inside the country. Since for the settlers political imperatives took precedence, planning and implementation of essential social services like health and education was not based on any principle of equity or efficiency. The post independence planners will be faced with the daunting task of correcting distorted geographical distribution of existing facilities for health, education, industry and transportation. Introduction of centralised planning structures is not going to be easy given the

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1. The terms "new wine in old wineskins" or "new music old harmony" are often used to sum up the desperate nature of such a situation.
  2. Tanzania Studies No.I: "Towards Socialist Planning" Tanzania Publishing House, Dares-Salaam. (eds) Uchumi Editorial Board 1974.

inherited fragmentation. It is in recognition of these problems that health as a sector likely to bring together all other sectors because of its individual, family, community and national character and subjective and objective nature; is considered. Further, the suffering inflicted by the underdevelopment of the African peoples, manifested itself most strikingly in their state of health. Since, as was observed in the previous chapter, health gives a good indication of changes within a nation, it would be illuminating to trace its growth pattern as a prelude to setting out the strategy for its future planning so as to reverse the process of underdevelopment of the Africans in Zimbabwe.

CHAPTER IV

THE GROWTH OF THE RHODESIA HEALTH SERVICES

"...social legislation is generated not in the arena of values (Wicker and Parsons) ... but in the reality of a struggle among classes, and primarily between the capitalist and the working classes, whose interests are intrinsically in conflict. In that respect, I believe that class struggle, which according to Marx and Engels, is the main motor of history, is also the main determinant of social and medical legislation".

Vincente Navarro: "Class Struggle, The State and Medicine, An Historical and Contemporary Analysis of the Medical Sector in Great Britain.



## THE GROWTH OF THE HEALTH SERVICE

### The Context:

The settler's prime concern was to secure a hold on the country. In the process, they underestimated the health problems they were to come up against in the new colony. The pegging of mine claims and the 'riding-off' of farms by the Column members meant that many of them found themselves in very remote parts of the country far from the sources of basic medicines. The medical supplies had to be brought from the Cape in South Africa, a long and costly exercise. Palmer observed that the rainy season of 1890 to 1891 was so severe and protracted that many prospectors, inadequately equipped with food, clothing and medicine contracted malaria and died.<sup>1</sup> The drive to get rich quick and the poverty of those who took part all combined to worsen the situation. The settlers however observed how the native population lived in these areas without experiencing similarly high death rates. The immunity of the native population to tropical common diseases was a contributory factor to the Company's exclusive concern and provision for the white settler population. This

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1. Palmer (1977) p.26. He actually talks at length about lone hunters and prospectors who died and were buried by the natives with no records or trace in the early days.

also gives the basis of later selective measures of preferential care that grew into government responsibility patients.

The African population lived in equilibrium with its environment. It had developed institutions to help restore it when it was disturbed and recognised ways and procedures had been long perfected and become part of the institutions that governed African life. Capitalist expansion under colonialism destroyed all this with the ferocity of its encroachment. The impact of capitalist penetration, observed by Marx as the most brutalising and dehumanising of human experiences, was most adversely felt by the indigenous African population. It brought with it diseases hitherto unknown to the Africans. The 'vibrant community' observed by George Kay (1970) was experiencing a multi-pronged onslaught on its institutions, culture and to its members! The process of underdevelopment was set in motion through land deprivation, taxation and imposition of levies; more brutally it took the form of forced labour in the mines and forced movement into barren, unproductive, fast filling Reserves. The disruption in normal life arising from food shortage and the resultant physical deterioration all combined to exacerbate the community's instability.

Whereas settler activities were recognisably aggressive, the missionaries were involved in more subtle efforts of substituting the traditional institutions with

western based and individualistic ones. A new view of life, emphasising individualism rather than collective community orientation, was being infused coated with offers of tennancy on Missionary farms and the opportunity to obtain an education.

As is argued throughout the study, health, because it is both subjective and objective in nature, is well suited as a barometer of the effects of these adverse measures on the individuals and the community as a whole. Whereas the missionaries concentrated on changing the African view of illness as distabilisation within the whole community and tribe which affected their other activities while they sought to restore stability; the administration concentrated on curative services which were used to ensure the labourers were treated and then sent back down the mines. Health services for the African population in Rhodesia were introduced in subservience to economic, political and socio-cultural goals. The health sector grew in response to the dominant ideology of white supremacy and superiority of the western cultures including their religious practices. Accordingly, the dispersion of the sector facilities was consistent with white settlement patterns, the demands of commerce and the missionary religious success and mission location.

A number of questions are raised at this point which should enable us to relate the issues raised in this chapter to the earlier ones and to the rest of the



study. Is it possible to analyse the growth of the health services in a bid to demonstrate the adverse effects of industrialisation and the inequity in distribution that accompanied the economic growth drive of the colonial state? To what extent did the divergent economic and political views between the two races lead to perverse growth of the health sector? In the final analysis, the thesis is put forward that the health sector's inadequacies in fact mirror deeper seated political, economic and socio-cultural distortions which resulted from capitalist penetration in Rhodesia.

The questions posed above will be answered under the sub-headings; health provision and labour on the mines, provision for the white population and the growth of African provision, the role of the missionaries. The pattern of growth will be viewed historically with the role of conflict over land and class, as discussed in Chapter III, being identified. A number of factors had an influence on the sub-headings among which the following are recognisable: the mines and growth of mining compounds, railway and road construction, settlement on farms and farming compounds, creation and occupation of reserves, missionary activities and Company administration, and the growth of manufacturing industry after World War II and expansion in urbanisation.

### Health Provision And Labour On The Mines

The nature of the gold deposits in Rhodesia was such that they were scattered throughout most of the country with irregular ore bodies which could peter out at any moment. (See Map 4(a)). The mode of operating these tended to be temporary with serious adverse effects on the provision of accommodation and working conditions for the African labour force. Cost minimisation and output maximisation became the two fundamental imperatives if profits were to be made. Indirect expenditure had therefore to be kept to the absolute minimum in these mines which made them unattractive to the African workers vis-a-vis the Rand. The Medical Director in 1909 summed up the situation when he observed that the geographical and financial limitations facing the mineowners and his department which had to inspect conditions in the mines, made it difficult

"to enforce sanitary control and generally protect the natives from the evils arising from the nature of their occupation".

The landlocked position of the country contributed to the high overhead costs thereby increasing the pressure to cut the indirect costs. Whereas the small mine workers could resort to less capital intensive methods of mineral extraction, the large companies could not operate without large capital. The period between 1903 and 1908 therefore saw large companies producing

only 40 per cent of total gold production. Since they were most affected by labour drift to the South and state requirements for better working conditions, they sought ways of fighting these enforcements. They formed the Rhodesia Land and Mine Owners Association and the Rhodesia Chamber of Mines which became very active in resisting legislative measures stipulating minimum working conditions, diet, accomodation, compensation and hospital facilities at mining centres. The small mineowners also had their own associations while unorganised black labour remained without any representative voice and thereby continued to be exploited. Practices such as not protecting underground works by using timber, led to 44 deaths at Ayrshire mine which also had at any one time five workers using light from a single candle; instances which passed with little official action.<sup>1</sup> In many instances, it is the mineowners who attracted the sympathy of the local compound inspectors instead of the poor workers. Van Onselen 1976 comments that:

"...it was the intense exploitation of cheap African labour throughout the history of the industry that made the greatest contribution to establishing its (mining) profitability. Above all else, it was .. reduction in the black wage bill, that ensured the long term survival of the industry, its expansion and development".<sup>2</sup>

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1. Charles Van Onselen, p.23.

2. Ibid p.24.



In the early days of speculation, no accommodation for African labour was provided so that the workers had to build huts during their own working hours. New arrivals found themselves with little or no accommodation from the wind and rain. Reports of miners living in 'rough grass and pole shanties' and of ill treatment, poor food and housing were actually admitted by the Administrator in 1901. When the big companies started providing wood and iron compounds, the accompanying discipline they exerted was resented by the workers. In addition, provision of housing for only half the workforce, allowing for alternating usage of the accommodation because of shift work, added to making the situation unhealthy and intolerable to the workers. The government health inspector's comments in this regard, that it was not necessary to provide for all the workers, demonstrates the extent of the collusion between the mineowners and the health officers of the state in underproviding facilities for the workers. The lack of privacy in the barrack like accommodation, the mixing of men with varying socio-cultural backgrounds, added to their separation from their families and community; all resulted in unbearably psychological stress on the workers. Finally the lack of protective clothing and the varying temperatures led to the contraction of pneumonia which led to very high death rates on the mines as the Table 4.1 and Graph 4.b show. New diseases like scurvy, resulting from inadequate and

TABLE 4.1

DATA ON SOUTHERN RHODESIA MINES 1906-1933  
TOTAL NUMBER OF AFRICANS EMPLOYED, MORTALITY FIGURES  
FROM DISEASE AND FROM ACCIDENTS

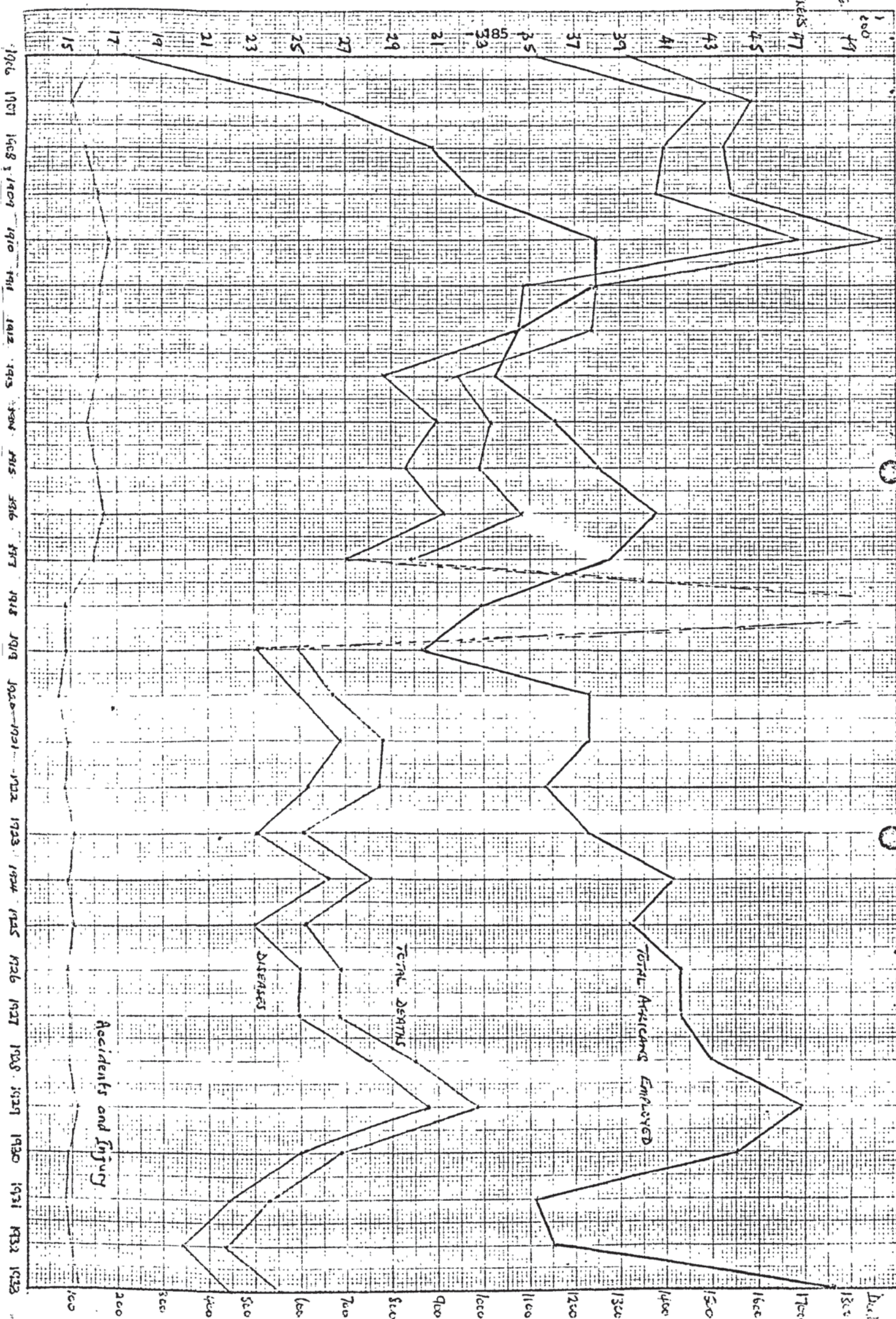
YEAR	AVERAGE No. OF WORKERS	No. of DEATHS FROM DISEASES	No. of DEATHS FROM ACCIDENTS	TOTAL DEATHS	RATE PER '000
1906	17381	1163	157	1320	75.94
1907	26098	1486	102	1588	60.85
1908	30865	1397	132	1529	49.54
1909	32721	1383	161	1544	47.19
1910	37826	1682	182	1864	49.28
1911	37909	1085	164	1249	32.95
1912	34494	1073	163	1236	35.83
1913	33543	783	158	946	28.20
1914	36100	897	135	1032	28.59
1915	37928	832	159	991	26.13
1916	40520	911	172	1083	26.73
1917	38461	700	149	841	21.85
1918	32766	3629	88	3717	113.44
1919	30296	507	90	597	19.71
1920	37669	599	75	674	17.90
1921	37605	689	94	783	20.82
1922	35718	618	86	767	21.47
1923	37482	504	105	609	16.25
1924	41286	665	89	754	18.26
1925	39386	505	105	610	15.49
1926	41617	598	91	689	16.53
1927	41635	595	94	689	16.55
1928	42940	756	94	850	19.80
1929	46811	875	110	985	21.04
1930	42047	598	91	689	16.38
1931	35202	444	87	531	15.08
1932	36068	343	94	437	12.12
1933	48242	444	111	555	11.50

Source: REPORTS OF PUBLIC HEALTH (SOUTHERN RHODESIA)  
Quoted in Charles Van Onselen (1976), p.50



GRAPH: 4.b

AVERAGE AFRICANS EMPLOYED IN THE MINES (1906-1933), TOTAL DEATHS, DEATHS FROM DISEASES AND DEATHS FROM INJURY.





poor diet which only required increasing food rations, claimed hundreds of lives. In fact as shown on the graph, diseases claimed more lives on the mines than accidents and injury. Table 4.2 shows the breakdown of the diseases that caused deaths on the mines.

The company administration was interested in recovering its investment, raising its assets value and increasing white immigration and therefore could not afford the closure of mines on the grounds of inadequate provision of working conditions for Africans. The mineowners were fully aware of this. It is not surprising therefore that regulations governing overcrowding of 1905, were never enforced. Commenting on this, the Medical Director stated that he was

"unaware of any mine where the conditions of housing of natives even approaches the standard laid down"<sup>1</sup>.

By this time, the workforce had expanded five times in nine years. The spreading of disease therefore was rampant. Phthisis, a disease which arose solely from the nature of mine work killed over 700 people between 1900 and 1933.<sup>2</sup> Instead of the Administration enforcing measures to improve working conditions and

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1. Charles Van Onselen, p.38

2. Ibid

TABLE 4.2

CAUSES AND RATES OF MORTALITY AMONG NATIVE MINERS

CAUSES & RATES	YEARS					
	1906	1907	1910	1914	1915	1921
CAUSES:						
Pneumonia	349	704	1043	196	442	253
Scurvy	104	203	78	180	35	9
Dysentery	80	118	124	69	43	17
Phthisis	62	59	75	-	48	39
Bronchitis	-	65	59	-	21	32
Acc.& Injury	n.g.	102	182	135	159	94
Malaria	-	-	39	222	44	56
Typhoid	-	-	-	15	-	-
Blackwater	-	-	-	2	-	-
Heart	-	-	36	-	29	-
Intestinal	-	-	30	-	25	26
Syphilis	-	-	-	-	7	8
Diarrhoea	-	-	-	-	2	5
Debility	-	-	-	-	16	12
Influenza *	-	-	-	-	-	113
Others	148	272	198	213	120	119
Total (for Causes)		1588	1864	1032	991	783
MORTALITY RATES / '000:						
Diseases	51.67	56.94	44.47	24.85	21.94	18.32
Accidents	-	3.91	4.81	3.74	4.19	2.5
Total Rates		60.85	49.28	28.59	26.13	20.82

\* - The Influenza epidemic of 1918 claimed  
3000 African mineworkers' lives  
n.g. - not given

Source: PUBLIC HEALTH REPORTS

health care facilities, the Chief Administrator Milton in 1907, concerned that the affected workers would infect others, asked employers to discharge them so they might die in the Kraals! Onselen writes that many workers died on the way to their reserves. The practice of sending diseased workers back to the rural areas meant that diseases hitherto unknown in these now fast crowding reserves, began to spread. Since no health services were available there, many people died from curable diseases.

The crowding in the mine compounds led to insanitary conditions and pollution of water sources which in turn led to the spread of dysentery and diarrhoeal diseases. Even large mines like Globe and Phoenix could only construct a 'corrugated iron barn' to function as a hospital, under pressure from the Administration. In this case, patients had to share the facility with corpses for twelve or more hours. Other bigger companies were even worse, spending one-twenty-fifth the amount spent on a white manager's house on a 'hospital'. In 1905 the Compound Inspector commented that none of the facilities at the mines could warrant being called a hospital.<sup>1</sup> By 1913, only 16 of the 488 mines of different sizes were said to have 'a good properly equipped hospital' (Public Health Report 1913, p.40).

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1. Onselen p.39.



In 1908, regulations were passed governing the diet of the black mine workers.<sup>1</sup> These remained in force until 1933. Doctor Fleming the Medical Director noted that it would be impossible to introduce the largely generous rations on the Rand on account of the expense, thereby demonstrating the official sympathy towards the mineowners to the detriment of the workers.<sup>2</sup> Even with these minimal requirements, mineowners acquired mealie meal containing a high percentage of husks or inadequately ground maize. This caused intestinal problems among workers. The workers were required to work twelve hour shifts a day for seven days a week. When the 1909 provision to limit shift lengths was introduced, only a few mineowners adhered to it. The introduction of a compulsory rest day in 1914 was strongly resisted by the industry and the Medical Director could only express concern at the non-adherence. Legal action delays against mineowners even for cases of non-payment of wages demonstrated the extent to which even the legal system passively backed them. Light sentences were passed after very long delays in bringing the cases before the magistrates. Van Ouslen (1976,p.70) quotes from correspondence from the Medical Director to Secretary Department of the Administrator that:

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1. Ibid p.44. The government notice produced a great outcry and in 1911 the small mineowners were opposed to the meat rations.
  2. Ibid p.44.

"Even well into the 1920's, ... the decision on whether or not to prosecute a mine owner for a breach of the labour regulations could take as long as nine months".

He further observes that:

"... cases involving the withholding of wages were frequently not heard by magistrates at all. (PHR 1924 p.5) For black workers, this was not necessarily unfortunate since magistrates were extremely reluctant to pass sentences on mine owners anyway: it was common practice for magistrates to postpone sentencing until the employer had been given time in which to pay his workers. And since the initiation of prosecution itself was subject to lengthy delays, workers could wait as long as two years to recover wages due to them".

(December, 1926. Debates in the Legislative Assembly, Vol.5)

Reported figures, which understate the actual numbers, show that in the thirty years to 1930, 3000 workers lost their lives from accidents in the mines while 30,000 died from occupational diseases, the result of capital penetration into a hitherto 'backward nation'.<sup>1</sup> The African population therefore paid a very high price for the economic growth of the country.

Despite the fact that the first compound inspectors were appointed in 1900, their effectiveness remained very limited indeed because of their lack of authority, the distances they had to cover, the means of transport

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1. Onslen p.55. In 1918 the Spanish flu killed nearly 3000 workers, 7% of compound population.

which was by mule drawn cart, the calibre of the persons appointed at the low wage then offered and the administration's attitude towards mine owners. They were attached to the Native Affairs department and the powers they were given were always measured against the profitability of the mining industry. It was only after the passing of the Mines and Mineral Ordinance of 1907 that their powers and numbers were increased. By the end of 1912, the inspectorate staff was one medical inspector, five full time and one part-time compound inspectors, to assess the conditions of 3500 workers!<sup>1</sup> Onslen concludes that:

"legislation designed around the minimum standards to maintain health, the inadequacies of the system of compound inspection, and the lenient sentencing of magistrates, thus made possible<sup>2</sup> the most brutal exploitation of black workers."

In theory, mineowners were supposed to provide hospital beds for 2 per cent of their labour force, but in reality none of this happened for even large mines like Wankie with high health risks, had only 25 beds for its 1500 employees in 1910. In the Gwanda area, which had the highest concentration of mines, (see Map 4.a) one doctor served all of them. By 1918, only 56 doctors were available for 308 operating mines

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1. Onslen p.69.

2. Ibid p.71.



employing nearly 33000 black workers.<sup>1</sup> Even then the doctor could only manage one weekly visit which included seeing the farmers in the area, and the skilled white workers before the black miners. From very early on therefore the availability of care was not related to the need. Most mines employed a white nurse or gave a white foreman responsibility for health care on the mine. Others employed educated Africans as male Orderlies at the mine 'hospital'. It is little wonder that hospitals were dreaded as places of death by the black workers. Mine health services therefore developed in a haphazard manner subservient to the industry's profitability. Onslen writes that:

"the poverty, violence, squalor and insecurity of compound life that was part of the 20th century industrial dispensation in Rhodesia, was very far removed from the life which African men and<sub>2</sub>women led in their traditional communities."

In 1914, Oswald E Jackson concluded his report on the study of the prevalence of pneumonia among native labourers by observing that

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1. Onslen p.58.

2. Ibid p.178.

"the conditions under which the native mine labourer lives and works break every law for the prevention of disease in question. His environment is wrong, his climate unsuitable, he is over fatigued, overcrowded, works in an insanitary, moist, stagnant atmosphere; he is not properly clothed; he is not properly fed, as regards times and methods of feeding; above all, he is unintelligent, or at any rate unteachable as regards those conditions which he should personally avoid; lastly, his system is undermined by malaria..."

The Table 4.1 shows clearly that the major killers in the mines were not the making of the labourers who were in fact unwilling parties to the whole exercise forced into it by coercion. It is difficult to see how the African workers can be made to blame for their condition in the light of the discussion above. The weight of the external factors to his limited internal system were overwhelming so in giving in, thousands of lives were lost and many more which depended on them were made miserable and unbearable.

The government's concern to industrialise and create demand for its internally produced products and its policy of not providing health facilities for mining concerns meant that legal compulsion for the provision of adequate services to African miners could only yield the desired effect if strictly enforced. It was not until after the Second World War, faced with keen competition for labour from other industrial sectors, that the mines made some advances in providing reasonable health services for the mine workers.

At the formation of the Federation, mine managements actually expanded their health services. In some cases like Wankie, where the whole town is mine owned and the mine hospital is the only facility for the area, the government pays the mine for patients which are its responsibility. These payments amounted to £15,765 in 1957/58<sup>1</sup>. The government further pays 50% of the running costs of African clinics. It is worth noting that other industrial concerns do operate clinics and hospitals, one of the most notable being Triangle in the South East sugar estates. At the end of 1965 the situation regarding the mine hospitals was as follows.<sup>2</sup>

Numbers employed	:	Europeans	1597,	Africans	18352
Hospital beds	:	European	32,	African	894
Admissions	:	European	905,	African	18678
Outpatients	:	European	10748,	African	86809
Accidents	:	European	190,	African	2682
Medical Officers	:	Full-time	7,	Part-time	17

The ascendancy to power of a right wing white minority regime in 1965 meant that the pressure to improve the conditions for black workers was lifted in favour of a

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1. Report of the Commission of Inquiry into the Health and Medical Services of the Federation, 1959. para.70. p.16.
  2. Report of the Secretary for Health, 1965, p.28.



full industrialisation drive in the face of international sanctions. As in the period of capital penetration, the workers suffered most from local industrial expansion

#### Provision For The White Population

When the Company railway line reached Bulawayo, the supply of medicines for the settlers, the administrators and the miners was a priority. If Cecil John Rhodes was to realise his dream of colonising Southern Rhodesia, it had to be made habitable for the white population loyal to the British crown. Not surprisingly therefore, health provision was made at settlements to distribute malaria tablets and provide basic treatment. This meant that staff, nurses especially and midwives had to be recruited all the way from England, a very expensive exercise. In 1899, nurse training for certified nurses was started in Bulawayo, followed in 1901 by another centre in Salisbury. These were the main centres, but minor ones were springing up with their populations also increasing. By 1901, the European population was 11,000. From the early days, European birth and death rates were recorded. The trend for selected years is shown in Tables 4.3 and 4.4. The mortality rates for the under one year olds is shown as well. The trend in European population compared to the African one is shown in Graph 3.3.

TABLE 4.3

EUROPEAN DEATHS, NUMBER OF BIRTHS AND INFANTILE DEATH RATES

YEAR	No. OF DEATHS (under 1 year)	No. OF BIRTHS	INFANTILE DEATH RATE PER 1000
1914	56	753	74.37
1915	60	784	76.53
1916	51	815	62.58
1917	48	855	56.14
1918	75	789	95.06
1919	63	756	83.33
1920	57	815	69.94
1921	57	913	62.43
1922	54	909	59.41
1923	70	937	74.71

Source: SOUTHERN RHODESIA PUBLIC HEALTH REPORTS

TABLE 4.4

EUROPEAN POPULATION, BIRTHRATE AND IMR FOR SELECTED YEARS

YEAR	BIRTHRATE	IMR PER 1000	POPULATION
1901	-	-	11000
1904	23.9	-	12600
1907	26.9	115	14000
1911	27.1	105	23600
1921	27.0	62	33600
1926	23.8	49	39200
1930	24.2	45	48400
1931	23.6	45	49900
1936	23.4	49	55400
1940	28.4	40	61450
1945	25.3	35	82500
1950	26.3	35	138000
1955	25.5	21	-
1965	17.6	23	219000

Source: PUBLIC HEALTH REPORTS AND SECRETARY FOR HEALTH REPORTS

In the early days, the main causes of infant deaths listed were premature births, congenital disability, diarrhoea, dysentery, gastro-enteritis and dental problems. From 1914 however, the main causes were congenital disability, malaria, influenza, convulsions, pneumonia and acute bronchitis. By 1965, it could be said that a pattern of diseases similar to that which occurred in Britain during industrialisation was discernible in the European community.

The important point being made above is that from the colony's inception, responses to European health were swift, ordered and expanded with the increase of the settler population. A system of records was kept and a flow of supplies established and maintained. Within a relatively short period, nurse training had been instituted and a skeletal structure for home deliveries set up. This could be put down to the simple reason that the services were meant to encourage settlers to stay and attract new immigrants. Despite the high initial costs of setting-up the Service, the Company was prepared to invest in it in the full knowledge that the returns in industrialisation and economic development would be significant.

As we observed above under the African labour services care of the white skilled staff on the mines was undertaken by the doctor to the mine. Where a mine was not big enough to employ one, the Government



District Medical Officer usually did the job. As an incentive to District Medical work, these doctors were paid by the Ministry for extra district work among these lone mineowners and scattered farmers.

In other cases, use was made of service facilities in the nearest town which usually had a private practice since almost all medical practitioners ran a private practice in the town. To attract doctors, the Company had offered generous terms including land holding, but most attractive were the urban postings which had to be filled before any rural postings were made. The Company had taken care to recruit doctors like Andrew Fleming as early as 1894 whom it made Medical Director (MD) in 1897. He held that post until 1930.

From the very beginning more care was taken of the white population. Even as far back as 1906, the insane were sent to asylums in the Cape Colony, Natal or Transvaal. Whereas no records or returns were made on the African population, the Medical Director (MD) could comment on the white paupers that,

"the expenditure on the European pauper sick cannot be said to be a severe tax on revenue .. returns are now being kept.." <sup>1</sup>.

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1. Southern Rhodesia, Public Health Report 1906.

Given the fact that the African population was already paying hut tax and other fees, the early surfacing of the above white mentality shows the narrowness of the settler attitudes. Prior to 1908, a District Service was operative in each area under a District Surgeon. The increased demand meant that changes had to be made. Three new officers were appointed, the service was extended and the health department took over Salisbury and Bulawayo provision from district surgeons. Gatooma hospital was opened in the same year but the shortage of doctors meant that an Assistant under the Hartley hospital doctor's supervision had to be appointed. What comes out clearly from this is that the health facilities were extended in response to farming, mining and construction expansion. With the increased settlement on the highveld and the gold belt, medical appointments were made in 1909 at Inyati, Abercorn, Blinkwater, Rusape, Plumtree and Sinoia. At Gwelo, a new hospital was under construction. As Table 4.5 shows, by 1910 2121 white in-patients were receiving care in hospitals. It is notable that Bulawayo, and Belingwe had a Private Subscription Hospital not a government facility.

One of the incentives offered to the Pioneer Column members and early Company personnel, to entice them to live permanently in Southern Rhodesia was provision of free medical care. The British South Africa Police members, Defence Force Headquarters staff and civil servants engaged by the Company on special contract were



TABLE 4.5

## EUROPEAN AND AFRICAN ATTENDANCES AT HEALTH SERVICE FACILITIES

YEAR	EUROPEAN		NATIVE HOSPITALS		NATIVE DISPENSARY		LABORATORY SERVICE
	In-P.	Out-P.	In-P.	Out-P.	In-P.	Out-P.	
1908-	1581	n.a.	1617	n.a.	-	-	-
1909-	2361	n.a.	1648	n.a.	-	-	33
1910-	2121	n.a.	2437	n.a.	-	-	70
1911-	2177	n.a.	2251	n.a.	-	-	153
1912-	2313	n.a.	2797	n.a.	-	-	-
1913-	2258	n.a.	2927	n.a.	37	559	393
1914-	2149	n.a.	2201	n.a.	91	1092	478
1915-	2415	n.a.	2023	n.a.	61	935	883
1916-	2073	n.a.	2204	n.a.	Work ceased during the years of the Great War		-
1917-	2384	n.a.	2518	n.a.			-
1918-	2805	n.a.	2364	n.a.			339
1919-	2868	n.a.	2330	n.a.			761
1920-	3123	n.a.	2949	n.a.			560
1921-	2273	n.a.	3196	n.a.	79	467	814
1922-	2976	n.a.	3053	n.a.	196	877	807
1923-	3310	n.a.	3015	n.a.	No separate records of work of the Native Dispensaries		1457
1924-	2833	n.a.	3991	n.a.			1714
1925-	3524	n.a.	4301	n.a.			2309
1926-	3827	n.a.	5168	n.a.			3464
1927-	4231	n.a.	5178	n.a.			5612
1928-	4995	n.a.	6137	n.a.	372	3136	7006
1929-	5041	n.a.	6663	n.a.	544	-	6062
1930-	5522	n.a.	8180	n.a.	657	-	8599
1931-	5093	10504	7466	7363	775	-	9295
1932-	5369	8594	7924	13487	625	132	15921
1933-	5972	8996	10057	13563	4522	9553	19173
1934-	6264	10135	10230	27273	6062	14777	21036
1935-	6820	11866	11468	24700	11490	23987	24390
1936-	7642	14345	13318	36895	11744	22704	36006
1937-	8040	22685	13704	44521	21490	46155	39137
1938-	*	-	19731	48479	28135	53955	-
1940-	*	-	-	-	28762	57890	-
1945-	*	-	-	-	66758	203476	-
1950-	*	-	-	-	127497	296730	-

n.a. : Not available; In-P. : In-patients; Out-P. : Out-patients

\* : Not shown because it is intended to show changes in African take-up.

Note: The growth of the service pattern is shown above. Of importance is the expansion of the native dispensaries for these catered for the rural population. A gradual increase shows from 1933 and yet native reserves policy was introduced and rigidly enforced following the suppression of the risings in 1897 and 1914. Source: S.R. Public Health Papers, 1937.



Government responsibility patients. The Ministry recovered all amounts spent in respect of these people from the treasury. Herein was rooted a practice whereby the top administrators, who were the best paid of the Company administration employees and other senior staff received free care from the state, paid for by the peasants, workers and subsistence farm employees and tenants through taxation and fees. This is not to say that the whites did not pay any income tax and indirect taxes. It is meant to emphasise that they got in return, more than the value of their contribution. The Civil Service Board of Enquiry in 1910 recommended that:

"the payment to hospitals for treatment of government patients and paupers should be discontinued".<sup>1</sup>

It persisted however.

'The predominance of the individualistic approach to health was underlied by the Medical Director's comment in 1911, during which year a decision was made to construct a new hospital in Salisbury in addition to the existing one which had 41 European beds and 29 African beds. Regarding the practicability of community action he noted that:

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1. S.R. Public Health Report 1910 p.14.

"... concerted crusades against the mosquito and its haunts are not applicable to the conditions existing in Southern Rhodesia and the care of his health must be very largely left to the intelligence and judgment of the individual".<sup>1</sup>

Even regarding the medical profession, they regarded their knowledge as their 'capital and stock-in-trade' and emphasised individuality. Capital penetration had transferred all its structures with the result that no aspect of life remained unaffected. Whereas illness and cure in the African traditional context involved the whole family and sometimes community, the Western approach centred on the individual.

By 1913, 19 District Surgeoncies existed, which corresponded with the magistracies. Their functions were to attend to magistrate centre's staff and on payment of a grant, attend to settlers in the district. The District Surgeoncies attempted to solve the problem of scattered white populations who it was claimed could not be charged remunerative fees. Travelling on visits to lone settlers was difficult and expensive, so urban areas were more attractive both professionally and remuneratively; only after all posts therein were filled could staff come forward for rural work. The Administration instituted an education campaign on malaria, through lectures, articles in the press and

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1. S.R. Public Health Report 1911.

pamphlets all directed at the settlers but with the urban population least affected benefitting most.

The entrenching of social attitudes that ensured white superiority was vigorously embarked on irrespective of costs. The new Salisbury European hospital was set up after rejection of the proposal to set up a block of white beds in the existing hospital because the native section formed the old part of that building. Commenting on the completion and occupation of the new hospital in 1914, the Medical Director observed that:

"This has necessitated a duplication of establishment and material, and is an expensive<sup>1</sup> and in many ways unsatisfactory arrangement".

In another demonstration of hatred and dislike, this time for Afrikaners, the Government Medical Officer for Victoria noted in the annual report of the same year (1914) that,

"Several Dutch treks, as in 1913 consisting chiefly of poor whites",

again inundated the district. Now faced with having to care for the Africans as well as 'poor whites', the Administration chose to retain the image of 'no-poor-

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1. S.R. Public Health Report 1914.



whiteism' which involved medical officers visiting these trekkers, passing through reserves but without attempting to provide for the African population there; despite the fact that it paid the taxes which financed the white's care.

The outbreak of the First World War was characterised in Southern Rhodesia by a demand for medical men and nurses to serve in the army. In 1915 the formerly subscribed hospital at Belingwe came under the government which had 183 beds in institutions up and down the country's urban centres - an increase of 23.6% from the bed size in 1910 of 148 beds. In the same period, in-patient care increased by 13.9%. No records were available on outpatient attendances. As shown in Table 4.3, a high infantile death rate of 76.53% per thousand was recorded, indicating perhaps the effects of a fall in white maternal and child health care. Over this same period, African dispensaries manned by a medical officer had to close down because he was withdrawn for active service.<sup>1</sup>

During the war no public health reports were printed so the 1919 report embodies all the others. The Public Health Bill was under preparation. The interesting

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1. These dispensaries constituted what was labelled the 'Ndanga Group' the resident medical officer of which was called for active service.

feature of this period is the resorting to state power so new legislation was all based on health legislation in the Union of South Africa. This explains the racial tone of regulations in this country by comparison to elsewhere in black Africa. Examples include the Medical and Pharmacy law in force, which was the Medical Act of the Cape Colony of 1830, which dealt with admission to practice of medical practitioners and chemists. In addition the rising proportion of Dutch white population is shown by the figures of births by parents all Dutch, in 1912 they constituted 19.4% of all births, in 1916 they rose to 20% and by 1919 the figure was 25.8%! This explains the hardening of anti-African attitudes. The growing influence of these new immigrants was demonstrated by the fact that despite official views that; posting to rural areas led to 'deterioration of professional skills on account of lack of use'<sup>1</sup> and resignations due to Medical officers' lack of practice and the soul 'clogging effect of enforced 'idleness'; the administration in that year proceeded to give a special grant of £100 per annum to District Surgeons to attend to farmers and settlers living outside a 10 mile radius from the surgeon's residence! Here was clear discrimination in the application of funds to which, as Table 3.2 shows the African population contributed heavily. The Surgeons in some cases

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1. S.R. Public Health Report, 1919 p.9.

actually passed through some African reserves. In the same year a Medical Inspector of Schools was appointed from England to institute care for European school children. This was not extended to African schools and in view of the fact that Native Reserves policy was being enforced and reserves were crowding, the fall in food availability and disease spread as a result of overcrowding and bad housing meant that these needed it more than the well nourished kids. A feeling of having been appointed to cater for whites only most likely precluded the Inspector from raising the matter of African school children.

The architects of the Rhodesian health services were over-concerned about the individuality of the doctor to the point where, in fact, health centres and dispensaries were sited and constructed to the convenience of the District Surgeons, who had been given a further concession of private practice. Not only could the new immigrant doctors (at the end of the war) be farmers but they could practise privately in the nearest urban centre in addition to the government grant for visits! These were lucrative conditions which account for the growth of medical practitioners as part of the governing and ruling class which wanted to see the continuance of white supremacy and were deeply opposed to black radical changes in approach. The real danger also existed that black doctors trained under this school and who worked with it, in the system were granted equal status and therefore had vested interests



in the continuance of some of these practices. This will be examined in greater detail later; and it will be shown that this class interest will prove an obstacle to radical health care provisions based on equality of access.

The year 1920 was accompanied by the introduction of the Foods and Drugs Act and the Leprosy Regulations. It is also noticeable that because of vaccination campaigns by the District Medical Officer for white children on farms and schools, the IMR was flattening out at 69.9; 62.4 in 1921 and 59.4 in 1922. In this period European standards had improved and white workers who were unionised had obtained economic concessions in return for their votes in the forthcoming referendum for responsible government in 1923. By that year the new familiar pattern of medical practitioners over-concentrated in urban areas was clearly established. Of the total number of practitioners, 65.5% were based in the eight main centres of which Salisbury and Bulawayo had 68.4%. Of the total number of European beds by 1925 the two cities had 48.5%. Bulawayo had started as a private subscription hospital and not under government control, but it was only taken over in 1925.

The structure of the Public Health and Hospitals department as it was called in 1924, falling under the Minister who held the post of Colonial Secretary; was as follows.

Department of Health Structure 1924



Source: S.R. Public Health Report, 1924.

The hospitals' expenditure went up in 1924 by 1.3% to £43810 (see Table 4.6). In the following year it increased considerably by 29.1% to £56537. A dental surgeon for white schools was appointed and pupil nutrition level checks were continued with recommendations for action following comparisons of levels. All possible measures were taken to improve the lot of the white sector following upon the granting of responsible government. The Public Health Act was passed in 1925 with all its wide ranging provisions regarding mostly urban areas - vaccination, notification of infectious diseases, prevention of malaria, segregation and treatment of venereal disease. In the following year, a Medical committee appointed under the Medical Act of 1830 based on the Cape of Good Hope, admitted practitioners, dentists and chemists into practice. This only worked for a

TABLE 4.6

GOVERNMENT HOSPITAL EXPENDITURE

YEAR	EXPENDITURE (\$)	% INCREASE (OVER PREVIOUS YEAR)
1922	42878	-
1923	43229	0.8
1924	43810	1.3
1925	56537	29.1
1926	61856	9.4
1927	67338	8.9
1928	80346	19.3
1929	90079	12.1
1937	168629	-
1938	159250	-
1940	188048	-
1945	601446	-
1953	2746766*	-
1958/59	3927686	-

\* : This expenditure figure excludes grants to missions and local authorities which stood at \$136,267 in 1953 and had increased to \$211,377 in 1958/59.

Note: Up to 1940, the expenditure on hospitals excludes any other expenditure outside hospitals.

Source: SOUTHERN RHODESIA PUBLIC HEALTH REPORTS (1922-40)  
REPORT OF THE COMMISSION OF INQUIRY INTO THE HEALTH AND MEDICAL SERVICES OF THE FEDERATION, 1959



year and then the Medical, Dental and Pharmacy Act (1927) was passed superceding the 1830 Act, and constituting a Medical Council of Southern Rhodesia.<sup>1</sup>

Responsible government had been granted in the face of fresh white moves to enforce the Native Reserves policy, so the Health Department responded by adopting more racialistic policies and started highlighting what they referred to as the problem of 'native proximity to white areas', being a menace to the European community. In his report at the end of a tour to assess and report on malaria in the North Dr Barratt stated that:

"At present the families of native police and gaol guards are living too close to and to windward of school. This is a danger to school children and others, which ought to be removed at once".

In the same report, as Government Medical Officer, he emphasised the need to protect the white Assistant farm manager's house from the menace of a nearby African compound.<sup>2</sup> Such was the attitude of the senior men in the Health Department of the now self-governing territory, towards the majority of the African population. His political ideology and the socialisation that breeds racism,

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1. This was made up of the Chief Medical Officer, a legal member and a medic not in government service, nominated by the Minister; 3 medical practitioners, 2 dentists and 3 chemists elected by the group. S.R. Public Health Report 1927.
  2. S.R. Public Health Report 1923, Report by the government Medical Officer on tour to study the malaria problem in the North districts.

over-rode the ethical demands of his training and were the main determinants of his policy initiatives.

It was these same officials who by 1929, when the depression was looming, started making a distinction between the older settlers of British origin and:

"a poorer type of white settler from the Union, who are woefully ignorant as a class and whose impoverished and unhygienic homes and general habits of life are a standing menace to themselves, their families and to those brought into contact with them, and must tend to the evolution of a more degenerate type of humanity, which may prove as great a problem in the future colony as it is in the Union of South Africa. Owing to poverty, and lack of capital, these persons tend to drift to the more remote and often more malarious parts of the colony and being markedly non-progressive, their presence in these districts not only reacts adversely on the health of the colony as a whole, but constitutes a bar to more beneficial occupation of the land by persons educationally and financially better equipped for the purpose."<sup>1</sup>

The implication of this is that in conformity with 'no poor-whiteism' philosophy, all efforts were made to improve the lot of the above whites who in class terms could have been lower than some of the Africans. Resources which could have been evenly distributed were poured to this sector which was, as we saw in previous chapters, backed by the state. Where class differences could have determined access, race was made an overriding determinant. A policy whereby the natives as carriers (despite observation above of some whites being carriers too), were in 1931 to be subjected to systematic medical control, was proposed. In that year,

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1. S.R. Public Health Report 1929 p.15.



the Nurses, Midwives and Other Persons Registration Act (1930) was passed which provided for the examination of these categories of staff in Rhodesia. By 1933 the provision for private hospital and nursing need was being seen in the department as,

"... of great benefit to the public, who receive in the private wards of government hospitals, services far superior to those which proprietary nursing homes can offer, and also accessory services such a bacteriological laboratories, X-ray and massage departments. Further, these services are given to the public at a cheaper rate than they could be provided by private nursing homes, who have to pay a dividend."<sup>1</sup>

Clearly the availability of such a service for whites only at government expense, in addition to their better economic position amounted to the poor peasantry and African workers, subsidising the rich whites. When the Medical Director boasted of

"adequate accommodation provided for all classes of the population ... in the private wards of the Government hospitals ... (as) is suited to the present stage of development of a young country"

This applied to whites. The policy of racial segregation or 'two-pyramid' policy meant that classes existed within racial groupings only, not between them. The government bore 69.2% of the cost of expenditure on hospitalised patients.

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1. S.R. Public Health Report, 1933, p.21.



Clearly,

"the government is bearing a large proportion of the cost of treating paying patients, in addition to that of treating free patients".<sup>1</sup>

The Medical Director in 1936 summarised in the most elaborate manner what drove the Administration towards the noted practices:

"if we wish to create and maintain a sturdy European population we must look to it that no section of the community is allowed to become depleted in health by reason of the lack of medical advice and assistance ... medical facilities are still a matter of primary importance, where such facilities are unavailable, there is a definite danger of a gradual deterioration taking place in the physical and mental capacity of section of the community penalised. The local effects of this are to be seen in the lowering of the standard of life and in the tendency towards that condition known in the Union of South Africa as 'poor whiteism' ... effects of this nature cannot be limited and eventually by marriage and intermarriage, they begin to exercise their malevolent influences upon greater and greater numbers of the population, until the general physical standard of the race is definitely weakened."<sup>2</sup>

In response to the above, a District Nursing service was introduced in Shamwa and improvements of the nursing conditions made in a bid to attract more nursing personnel locally. A bid to improve European health was made coupled with the opening of the first private enterprise general hospital in 1937, the St Annes Hospital in Avondale,

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1. S.R. Public Health Report, 1935.

2. S.R. Public Health Report, 1936, p.2.

Salisbury owned by the Little Company of Mary with 33 beds. In that year the gross expenditure on medical services reached 7.6% of the GNP.<sup>1</sup> The Map 4.c shows the location and dispersion of the facilities by 1938.

The most notable feature of the post war period was the demand for the creation of a ministry, which was formed in 1945 with a budget of £601,446 (see Table 4.6). With the increased white immigration and the noted coalition of white classes, provision for white health services continued to expand and improve until the formation of the Federation in 1953. Under the Federation one Federal Ministry of Health was formed with a Recurrent expenditure for Southern Rhodesia of £2.2 millions and Capital expenditure of £544000. Grants to Missions and local authorities totalled £136 267 which had to be topped up by the relevant authorities through fee charges or remittances from outside and rents and rates charges.

Two important points need to be made as regards the pattern of the services in the post World War II period. The first is that the industrial boom, increased industrialisation and immigration, meant that the power balance attained in the 1930's was being threatened. International capital was, as we saw in Chapter III, making an alliance with the revived African workers movements to challenge the white classes'

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1. S.R. Public Health Report, 1937.



coalition. All forms of privilege, health and education included, based on the two-pyramid racial segregation ideology, were being challenged as unworkable. The second which followed from this was the ascendancy of international capitalist influence as demonstrated by the formation of the federation. A new body of liberalism was slowly gaining political control and promoting an African elite which could afford to buy the best private medical care available. In addition Associate membership of the World Health Organisation, meant that in compliance with its regulations, preventive and promotive activities had to be extended to the Native Reserves, a move seen as 'misallocation of resources which could have been used to improve white health care', as deduced from the diehard white politicians utterances.

White hardliners' opposition to these moves to redistribute health as well as other national resources reached a head when ambulance vehicles donated to the Harare African Central Hospital in Salisbury, by the Red Cross in 1957 were taken and given to the white sector. Despite all these equalisation attempts white privilege persisted as evidenced by the Medical School intake.<sup>1</sup> Further, the introduction of the Councils Act (1957) and Community Development Strategy (1963); under which Native Councils, without any financial

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1. This will be shown in Chapter V on Health Services problems discussion.



sources of their own except native taxation and a small government grant, were to be responsible for rural clinics and schools, ensured that white health services remained superior. Whereas the Commercial Areas Rural Health Centres recruited State Registered Nurses and were visited regularly by a doctor, African council clinics were staffed by a medical assistant or an on-the-job trained nursing assistant without much supervision and inadequate drug supplies.

The break-up of the Federation and the declaration of UDI, saw the return to the hardline white supremacist policies of racial differentiation in provision including of health.

By 1965, the rate of African population increase was put at 120000 a year and European birthrate was declining from 18.5 to 17.6 per 1000; despite increasing infant death from congenital defects. It is perhaps illuminating to view the number, size and level of health facilities provision throughout the country by that year.

The following professional people were registered with the Medical Council of Rhodesia in 1965:

Medical Practitioners (includes temporary, provisional) and foreign registered )	861
Dental Surgeons "	124
Chemists and Druggists "	329
Opticians	42
State Registered Nurses	3018
Enrolled Nurses	5
Midwives	1295
Maternity Nurses	185
Medical Assistants (African Orderlies)	1292
Health Inspectors and Meat Inspectors	185
Health Assistants	57
Physiotherapists, Radiographers and Technologists	35

Not all the above were employed in the Ministry of Health although a majority was. A lucrative private practice existed which accounted for the existence of more than one medical register.

An analysis of the Facilities Table shows that for the African population the bed ratio was 1:332 including Missions but excluding specialist facilities and those for infectious diseases. The European bed population ratio was 1:186 in addition to the range of insurance and private medical aid which they could contribute to, which enabled them to obtain private care when they needed it. If for the African facilities we exclude Missions, the bed-population

ratio jumps to 1:499! It cannot therefore be over-emphasised how important missionary provision is. Its pattern of growth is the subject of the following section. Despite the African population's contribution to the treasury in taxes, they were left to the non-government agencies to cater for them healthwise. The changes in the level of African hut tax contributions over the years in discussed in Chapter III . In Table 3.2 it is shown how the percentage increases exceeded population and wage increases in the same periods. The only explanation for these changes is that the African workers and peasants were bearing steep increases in tax demands.



THE AFRICAN HEALTH SERVICES : THE ROLE OF THE MISSIONARIES

The situation in the native reserves was one of general neglect. As outlined in the section on Health Provision and Labour on the mines, services were only available on the mines. The health condition of the people in these rural areas remained unknown to the Administration which showed no interest except in as far as labour supply and land acquisition was concerned. The result of enforcement of Reserves policy however was overcrowding and increasing food shortages. The observation in 1906 by the Medical Director Fleming, that,

"District Surgeons continue to report absence of diseases due to insanitary conditions or overcrowding".

.. did not last for long. Workers who contracted infectious diseases on the mines carried them back to the rural communities with the effect that these started to spread among the hitherto safe peasants. The effectiveness of traditional healers who had done well under conditions of equilibrium with the environment enjoyed before forced movements, began to fade.

Whereas records were required to be kept by law on the health of mineworkers, statistics on rural African population were never kept. Attendances for treatment in the farms and settlement posts were however recorded. It was the fear of contagion which led to the provision of separate facilities to treat Africans at every white government hospital. In

addition, the district surgeons also attended to the African workers at the magistrate centres. Because of their proximity to European settlements and the fact that they came into constant contact with the whites, the urban dwellers were provided for from very early on. By 1908, 1617 in-patient attendances by Africans were recorded for that year alone in the Native hospitals (see Table 4.5).

In Chapter III it was demonstrated that even before the settlers set foot on Rhodesia, the struggle for the control of native minds was raging between the missionaries and the traditional institutions, which included the medicine men (who often doubled as the spiritual mediums) and the traditional birth attendants. When the colonial administration over-ran the indigenous population and instituted its own administrative structures, the missionaries' role was strengthened so they were used to pacify the natives and replace their social structures with colonial ones. It was no accident therefore that missionaries set up health posts and schools adjacent to their churches, assisted through grants by the government. The first mission health centres were established at Morgenster and Mount Selinda. Because of their location in the middle of expanding reserves, the mission centres began to be very much aware of diseases that afflicted the indigenous population. Meanwhile the Medical Director was still commenting in 1908 that :

"with the exception of Leprosy and Syphilis, we still remain very much in the dark as to the special ailments



to which the natives, in their own **Kraals** are most liable. They do not call on the whiteman's doctor, for they have their own medicine men, and their own treatment for the troubles known to them"<sup>1</sup>.

There was some accuracy in the above statement especially with regard to official ignorance on conditions in the reserves<sup>1</sup>. The District Surgeons, who were in the best position to know, only concentrated on the mines and the white farmers. Sufficient awareness however existed to warrant the observation that,

"the increase of the population in rural areas, and the springing up of new villages and centres, have created a need for Medical aid and hospital accommodation in those places, situated, as many are, far from the railway, with bad roads and<sup>2</sup> with big rivers to negotiate in the wet season."

With the Civil Service Board of Enquiry set in 1910 recommending that hospitals charge for care, the number of inpatients had increased in two years by 50.7% to 2437. Native vaccinations had also been increased but only in the urban areas and white settlements. It was not until 1912 that a scheme to bring medical aid within reach of the native population in the reserves was considered. As was to be expected, it was one that included the government and the missionaries; with the former setting up two centres - Ndanga and Belingwe and the latter, St Faith in Makoni and Kwenda Mission in Charter. The government undertook to

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1. S.R. PHR 1908, p.9.

2. Medical Director Fleming, S.R.PHR 1908, p.16.



provide mission expenditure for part of the cost of construction and for equipment, in addition to an annual grant towards salaries. This initial concerted effort was met with an unwillingness from the Natives to attend the dispensaries and hospitals, essentially because they were not sufficiently informed of the uses and benefits of these facilities which were all new to them. The government Medical Officer for Ndanga, Dr Williams, reported in 1913 that:

"The number of Natives I have treated has been too few to give any idea of the health of the native population ... when I visit the kraals the chiefs or headmen invariably deny that there is or<sup>1</sup> has been any recent sickness in their kraals."

The basic answer to this lay in the nature of the political and social relations between the two racial groups. The settlers had followed their victory with deployment of native administrators, and imposition of hut taxes and fee charges in addition to forced movement. It was natural for the harassed population to regard, with suspicion, the sudden change of heart, by the same people. The sincerity of the medical personnel was also very much open to question. Although they showed willingness bordering on enthusiasm towards providing education campaigns for the white sector, their reaction to Native unawareness was noticeably vicious: Director Fleming commented that:

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1. S.R. Public Health Report, 1913, p.15.

"It is true that it seems almost a hopeless task to force the Native to adopt the decent habits necessary to the preservation of society, but the enactment of further regulations and the stricter enforcement of those that exist, with rigid prosecution for the breach as is done in all well-ordered communities, would go far to put an end to this, and would materially benefit the health of the community." <sup>1</sup>

An authoritarian view was clearly expressed above, which illustrates the official approach to most matters of African Affairs. The Medical Officer in 1913 accordingly recommended to the department of Native Affairs that

"...as far as possible to adopt the principle of placing native dispensaries somewhere near Native Commissioners stations. The Native Commissioner is in the best position to influence the Native mind and can to a certain extent allay his fears and encourage him to apply to European doctors when sick." <sup>2</sup>

It is difficult to understand why a health officer could not see that the Native Commissioner's Office was responsible for implementing the Company Administrations detested policies of: forced movement to crowded and unsuitable for farming reserves, collection of hut taxes, dog fees, cattle dipping fees, and forced labour down the mines. This inability by the officials of health to overcome their racial prejudices led to a situation whereby the native political opposition to the native commissioner was extended

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1. S.R. PHR 1913,

2. S.R. PHR 1914, p.15. This put the struggle for health provision into the overall socio-political struggle for the winning of the native hearts and minds wherein the missionaries had a head start.



to Health Services. At the outbreak of the war the same Native Commissioners became Compound Inspectors on the mines with their dreadful conditions. Given the diversity of tasks he had to perform, how possibly could he cope? It remains however significant that in 1914 there was a very high outpatient rural dispensary attendance of 1092 people, a 95.3% increase over the previous year during which these units were opened. The fall in the inpatient attendance at the Native hospitals as well as white hospitals could perhaps be ascribed to the war manpower requirements. What is significant is the fact that government provided facilities at Mwembe (Belingwe) and Ndanga (Fort Victoria) all closed in 1915, the one because the Medical Officer resigned and the other because he had to join active service. The provision of simple remedies was therefore left in the hands of the native commissioners.

The fact that all legislation was based on South African Acts meant that the racial overtones therein were imported and applied intact. The pass laws introduced to direct labour to the mines affected urban blacks more than the rural ones. Because of the fact that the urban dwellers were under constant observation of the officials, since they posed a health threat to the whites, their movements were more restricted. In 1918, the Native Registration Amendment Ordinance was passed which provided for periodic examination and treatment of natives in employment in towns. The individual towns however had to apply for it. When by 1919 none had applied, a system of medical inspection of all natives in employment in Salisbury and



Bulawayo was instituted - this remained in force right up to the time of independence. The influenza epidemic of 1918 further fuelled the call for legislation to empower the Public Health department to deal with and regulate outbreaks. As the District Surgeons found out, it was those Africans who lived '... adjacent to mines or other centres of European occupation', who were most affected by social diseases, highly infectious, like venereal disease.<sup>1</sup> The expansion of industry especially tobacco processing which produced damp, heat and cold air caused pneumonia among the workers. In the Salisbury native hospital in 1920, 97 cases were treated with 26 deaths, and in 1921, it was 86 cases with 20 deaths. Clearly the manufacturing sector had also joined in the under-development of the indigenous population's health. A major striking feature of this whole period is the lack of public health preventive measures.

A number of features regarding African health services provision were discernible during the company's administration. Most striking however are the observations that, whereas it is the indigenous population's children who required regular inspection because of the nature of their crowded living conditions, the white children were inspected

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1. S.R.PHR 1920. This links industrial growth with the spread of social diseases and the appearance of diseases hitherto unknown to the indigenous people's cultures a further demonstration of Capitalist development of underdevelopment of health.

instead. Whereas it was the native population that was most in need of health education, vaccination and other public health measures undertaken by the ministry of health, the district native department and members of the British South Africa Police were in charge of rural health care. Since nothing was known of rural health, statistics should have been collected or a system instituted to obtain data on the African population for comparative purposes so as to identify the health gap and perhaps take measures to close it. No data on African births and deaths let alone disease incidence, was ever collected in the rural areas nor a system introduced. Other interesting patterns include the fact that the District Surgeon was paid a grant to visit individual white farmers and often passed reserves without even overseeing dispensaries. No outreach was ever intended for the Natives despite the fact that nurse training for whites had been introduced as early as 1899 in Bulawayo and 1901 in Salisbury. Instead, the administrative Native department was given the task. Even in the urban areas, where the natives were better off, native wards were built as appendages to European General Hospitals. Hence the assertion that the differentiation in health services provision mirrored the differences in economic, political and social structural make-up, does have a lot of credence.

When responsible government was granted 58 medical practitioners were registered in the whole country, but as we saw, they were mostly concentrated in the urban areas



where most of the white population lived. The nature of the health department organisation structure indicates clearly the white care curative emphasis. Since the missionaries had put all their weight behind the campaign for self rule, some concessions had to be made to them and to those African elite who had echoed their voices. The government decided to aid missions in return for provision of medical services in a given area. As a result, the American mission provided services to the whole of Mtoko and Mrewa districts in 1924. When the Public Health Act was finally passed in 1925 its provisions for vaccination, notification of infectious diseases, malaria in the villages and towns and the segregation of venereal disease patients; could not be carried out because there were no adequate outreach facilities. The missions did not do any preventive community work but merely treated those who turned up at their health posts. Those who were converted and who lived on their farms, had adopted western attitudes and rejected African traditional institutions benefitted; but they were a small minority. The ministers of religion themselves and their families were granted the right to free care in government hospitals.

The second half of the 1920's saw some significant changes in the health sector and other sectors which can only be attributed to the awakening of the African workers and peasants. As we saw under the section on Political Economy and origins of conflict, the Africans were realising now that the promises made by the whites in return for their support towards attainment of responsible government



were not being fulfilled. The religious and African elite groups who had purported to speak on behalf of the Africans could afford to pay for better care in the urban areas and at the mission centres. African movements and organisations like the ICU started to speak out at political gatherings, on the injustices of health provision. So a move towards increasing clinics and dispensaries, and an awakened interest in health problems like maternal and child welfare, morbidity and mortality rates both in employment and in the reserves was being backed by both whites and blacks but for varying reasons.

On the one hand were those who wanted:

"... to remove everything which concerns the health of the community outside the influence of politics, and to bring them within the purview of and the control of the people immediately concerned, that health administration is largely handed over to local authorities, and the costs made, a charge on local rates and outside of the Treasury control."<sup>1</sup>

These included health officials now under fire from African organisations, and other whites who felt government money was being wasted on African health forgetting that they contributed heavily through taxes and low wages. On the other hand were those who wanted to see 'an extension of the services amongst the Africans'. These also advocated for more public interest in management and control of hospitals,

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1. S.R. PHR 1927

the prevention and cure of diseases. In this group were the missionaries and white liberals and more interestingly, international capital, which wanted a healthy source of labour. Better still, it wanted an educated supply of indigenous labour so as to challenge the white worker power which was growing and with it the costs of recruiting external skilled white workers.

In the face of these pressures, the ageing Medical Director Fleming recognised the limitations to government health expansion and decided to assist missions to expand and vary their scope. They were most suited because of their location deep inside Native areas. A major problem for their health work was the lack of African orderlies, so further grants were made for training male and female nurses and midwives, establishing more clinics and purchasing drugs. This extension of grants in 1928 encouraged the missions to venture into previously unprovided areas; more interestingly, the government extended its provision with opening of centres at Buhera, Bikita, Kezi, Wedza and Tjolotjo. In reference to this expansion however in 1929, the medical director indicated that government facilities construction depended on the bouyancy of the economy rather than the needs of the people. This explains why the inpatient attendances, having reached 8180 in 1930 started to fall because of the depression. All the same, the expansion of the government outreach was marked by increased in-patient and outpatient attendances (see Table 4.5).

As has been pointed out throughout this study,



white political motives found expression in aggressive land policies which inevitably meant the pushing into more remote, unproductive and crowded reserves of the indigenous population. With African population now topping the one million mark, the Land Apportionment Act of 1930 could only exacerbate land problems and consequently health problems. Increased population removal from the highveld into the dry areas increased the problem of malaria which was officially viewed, as essentially

"... the problem (of) the native, ... any measure, therefore which reduces the extent of malaria among natives or prevents the infested native from coming into contact with white persons in the presence of Anopheline mosquitoes, will reduce this disease among the European population."<sup>1</sup>

The solution from the department was basically to keep out the infected natives from the remote areas, as distinct from ensuring through better provision and care, that those in towns, at government outposts and missions are covered. This therefore required establishing referrals out there, forms of communication between units and locally trained staff. The solution required co-operation of the native commissioners who were knowledgeable about native affairs and further that the natives bear the cost of the care.

This is a further illustration of how blind racialist politics affected policy making in all sectors. Despite

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1. S.R. PHR 1930 p.8.



clear evidence of the fact that the African peasants were subsidising the European money economy in addition to paying large proportions of their annual income to the treasury in taxes, (deduced from the comparison of Table 3.2 on hut taxes and the population and mine employment figures) from which they did not receive any sizeable services, the health officials were recommending that they pay for the health services. If this is set against our earlier observation that senior civil servants and religious ministers were entitled to a free service, and that white workers had two-thirds of their hospital care expenses covered by the government, a unique practice of the poor subsidising the rich was taking root in Rhodesia. In fact, with the white classes coalition of the 1930's this was built into the system and the list of those entitled to free services (see Chapter VI) increased in addition to the provision of private wards two-thirds of whose costs were borne by the government thereby making them cheaper than private nursing homes despite their being better equipped.<sup>1</sup>

What determined the location of the government facilities? Apart from the initial haphazard provision of dispensaries which could have been determined by how vociferous the area inhabitants were or how kind the native commissioner was; native facilities were sited:

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1. S.R. PHR 1933 p.21.

"...at distances 30-60 miles apart and from the central referral, eg the Ndanga group ..(since it was well known that the native will travel long distances to obtain medical assistance."<sup>1</sup>

This view is contradictory to earlier observations that the Natives were unwilling to utilise the white provided health services, expressed in the PHR 1914 p.15 and earlier by the Medical Officer of Ndanga, Dr Williams, in 1913. (See p ) Maurice King (1966) showed in his studies in East Africa that:

"the average number of outpatient attendances per person per year will be seen to halve itself about every <sup>2</sup>two miles for the hospital and the dispensary .....".

Without even viewing other factors like level of awareness, accessibility, disease severity and the quality of care, the basis of service planning was incorrect or grossly inaccurate in so far as it used those figures and principles.

The class struggles of the second half of the 1930's, created a situation which was confusing to those who had to interpret and implement the same government policy to two racial groupings living in the same country, in a different manner. The causes of this confusion were

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1. S.R. PHR 1934 p.12.

2, King, M. (ed) 1966: "Medical Care in Developing Countries; A Symposium from Makerere". Oxford University Press, London p.217.

discussed in Chapter III at length, suffice it here to briefly view them as the political and economic power struggle between the white classes and international capital. The latter was opposed to white protectionism and white supremacist ideology because it forced up white wage rates, restricted African competition and therefore interfered with the levels of profitability. Further, the State control over the economy aimed at ensuring that investment was directed towards generating economic development and industrialisation, which would increase demand for local produce, went against international capital's approach of investing in response to demand and continued dependency on the metropolis. International capital supported improvement of African services so as to ensure a constant labour flow and increased productivity. It supported African organisation (a feature of post World War Two period), into trade unions, because this challenged white workers' power and broke their skilled and semi-skilled labour supply monopoly. At different occasions in the last half of the 1930's, opinion in the department of health swang with the relative strengths of the above forces.

At one point, an increase in 'small base hospitals' manned by African orderlies and administered by the NC's was supported as:

"... reasonable ... (and) as an insurance for the protection of the health of the European and as an investment by the nation for the better maintenance<sup>1</sup> of its labour supplies in quantity and quality."

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1. S.R. PHR 1936



This was followed two years later, by an impassioned plea by the Medical Director, directed at the white population, based on the assertion that,

"the prosperity of a people depends upon the health of its individuals and human happiness becomes attainable when physical well-being matches mental strength and moral worth...".<sup>1</sup>

His comment that, the position of the natives was not known to him and his department and that opinions on them were based on conjecture from the impressions of the observers like the Native Commissioners, led him to concede that;

"... by the slow progress of evolution the Reserve Native, if left to himself, will gradually show the effects of European influence in the creation of a better type of habitation for himself and his family."<sup>2</sup>

Which shows the extent to which the health officials were influenced and subjected to the 'double-pyramid' politics of the State. The same MD went further to appeal to the mine labour employers to improve their rations because this would ensure an increased future supply of Native labour arising from an increase in native population. Clearly these officials were not at peace with the political directives, the white attitudes, their professional demands and the conditions of the natives.

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1. S.R. PHR 1938, p.4.

2. Ibid p.5.

It is interesting to note that continued missionary criticisms of extreme government policy also forced these health officers to attempt to cover their tracks by officially taking an extreme view consistent with the government or white philosophy, and practically doing something else. Map 4.c shows the distribution of the facilities and in Table 4.7 we show the position regarding African health services. Missionary provision increased during the war to a point where admissions in 1940 were 50 per 1000 and in 1945 73 per 1000. The siting of government clinics and dispensaries shows that they were built near gravel roads which were the only means of communication with the native reserves. Since the official view was that the natives would travel long distances to get the service, the units were located to suit the supply chains and administrators. The level of missionary provision from the break-up of the Federation is shown on Table 4.8.

Health facilities provision continued to improve with the increase in African opposition to the policy of racial segregation. Since the post war boom improved the relative positions of international capital and the African workers pressures in opposition to the whites hardline coalition increased. The formation of the Federation saw an increasing prominent role being played by the white liberals who were backed by international capitalist finance and who wanted to see an improvement in the African conditions so that a buffer middle class could be formed to cushion black majority demands. With the formation of the Federal Health Ministry in 1954 came a lot of real improvements





TABLE 4.7

HEALTH SERVICE FACILITIES PROVIDED (1965)

LEVEL	NUMBER	BEDS		IN-PATIENTS	
		EUROPEAN	AFRICAN	EUROPEAN	AFRICAN
1. Central Hosp.	2: Bulawayo Group	330	672	8825	22252
	Salisbury Group	435	840	10928	25355
2. General Hosp.	8: In other towns	393	922	8557	39132
3. District Hos.	29: In rural areas	128	2293	2061	83861
4. Rural Hosp.	62: In rural areas (African only)	-	3324	-	116673
5. Health Centre	92: In rural areas (African only)	Out-patients only			
6. Missions	67: In rural areas (African only)	-	4039	-	123231 *
7. Local Authority Services	Urban areas (Infectious diseases)	138	1025	1521	9158
8. Special Hosp.	Tb: Mpilo & Martin	-	300	-	1525
	St. Francis	80	-	13	-
	Ngomahuru (Leprosy)	-	80	-	529
	Ingutsheni (Mental Disorders)	239	525	137	1004
	Nervous Disorders	23	-	285	-

\* : This figure includes admissions for Tb patients, 2247.

Note: - The European figures include provision for Indians and Coloureds although these were separately provided; they form a small proportion

- Health Centres had one or two holding beds only for patients waiting to be taken to the referral
- Local Authorities ran clinics in addition to the infectious diseases facilities found in the seven main towns
- African population stood at 4,020,000 and European population (including Asians and Coloureds) at 239,700.

Source: SECRETARY FOR HEALTH REPORT (SHR), 1965

TABLE 4.8

PROVISION FOR MEDICAL MISSIONS

	1958	1962	1963	1964	1965
Number of Missions	64	65	64	64	67
Beds: Approved	2011	3000	3018	3061	3086
Actual	n.q.	n.q.	n.q.	3832	4039
Admissions	77822	106190	94496	111389	123231
Outpatient Attendances	1.3mln	1.7mln	1.8mln	1.95mln	1.74mln
Staff: Doctors	21	29	29	28	31
Nurses	87	132	137	127	136
Auxiliaries	143	231	310	245	227

n.q. : Not quoted

Note : The actual beds held were considerably more than the approved because of the overwhelming need in the Reserves. This increase in provision amounted to overcrowding which has bedevilled all the African health facilities.

Source: REPORT OF THE COMMISSION OF INQUIRY INTO THE HEALTH AND MEDICAL SERVICES OF THE FEDERATION, 1959  
SECRETARY FOR HEALTH REPORT (SHR), 1965

which included the construction of two Central Hospitals - Harare and Mpilo which had African State Registered Nurse Training. Midwifery training was also extended and maternity facilities provided at General Hospitals. With the expansion in African education among other things, was the founding of the multiracial University in 1957 under Charter. A medical school attached to the University started to train medical students of all races in 1963. The inequality of educational access between the two races in the Federation still meant that whites were dominant. Two Africans, two Asians, and Coloureds and 13 Europeans graduated from the first intake.

Whereas Hospital Committees and Management Boards were established during the Federation to assist in the decentralisation exercises and the encouragement of grass-root participation, they remained a feature of the Urban areas fully dominated by the White middle and upper classes. The introduction of community development as a strategy for improving African rural areas through local councils headed by chiefs, proved a failure. Efforts at extending preventive services through deployment of health assistants did not succeed because there was no back-up or fully developed support structures. The declaration of independence worsened an already bad situation for the rural African especially the mothers and children. The baby clinics run for the purpose of immunising children had unearthed a serious level of malnutrition throughout the country. An FAO/UNICEF programme of Home Economics and Nutrition Extension had to be terminated when UDI was



was declared in 1965. This meant withdrawal of funds and expertise which was helping the malnourished African child. This is a typical example of how political actions directly affected the health of the least able to fend for themselves.

## CONCLUSION

A number of lessons can be drawn from the growth pattern of the Rhodesian health service whose relevance will be further examined in the discussion of the present health and health care problems. It is clear that the provision was divided into white and black care from the beginning because of the dominant white philosophy of black inferiority. The relevance of class to accessibility within the social groupings comes out in the form of differential access between the Urban and the rural areas of both groups and the quality of care commanded. The well-off could always go to the private practitioners but provision of government subsidised private beds, exemption from charges of some groups and preferential care and access to rural facilities; all militated against provision based on need or equitable distribution of state health resources. Only the missions had a definite commitment towards the rural poor's health. Because health services like other social services, were very much affected by the changes in political moods of the ruling and governing classes, their rate of expansion contracted and expanded accordingly.<sup>1</sup> Their being influenced by the trends in

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1. The main lesson from these four chapters that comprise the first part of the study is the understanding of the behaviour of Capital and through the analysis of a particular historical experience, design strategies to plan for and manage it towards development of the country under study, using the health sector as the 'entry-point'.

white politics also made health services a target of African Nationalist criticisms. Of prime importance was the link between the health problems of the population (and therefore its need for more facilities) and the changes in Land Policy. Since all land related legislation was aimed at either increasing European land by taking from the African, or regulating African land usage, population pressure on land and deteriorating land productivity were the flash points of the conflict that ensued in Zimbabwe.

Besides the politically, socially and economically related problems, there were problems of organisation within the service and other technical ones. With time and the hardening of attitudes, these must have transformed; it is therefore the intention to examine the health and health services problems which were inherited from the white minority regime at the attainment of independence on 18th April 1980.



P A R T   I I

This part proceeds to deal with the problems of health and the health care sector in Zimbabwe and concludes with a discussion of findings on the ground which show the usefulness of studying opinions and face to face collection of information and data for planning and management in a dynamic crisis situation. This picture of the crisis<sup>at the</sup> time of independence and the period immediately following it, is one in which the role of socio-political factors is paramount and one for which a method of systemic planning for equitable provision will later, in another part, be drawn. The crucial link between the ill-health of the majority population and underdevelopment is brought out. The extent of the effect - immediate and over time - of economic, political and socio-cultural factors on health status, are analysed according to the broad social classifications existing. One striking aspects which comes out clearly is the gaping inequalities which exist in health between the blacks and whites, and between the urban and rural populations. The levels of these only are viewed here since their origins and history were the subject of Part I.

## CHAPTER V

### HEALTH: INEQUALITIES AND PROBLEMS

"Health, like happiness, cannot be defined in exact measurable terms because its presence is so largely a matter of subjective judgement ... it is a relative affair that represents the degree to which an individual can operate with effectiveness within the particular circumstances of his or her heredity and physical and cultural environment. What can be measured is disease, and in a particular society, the pattern of disease closely reflects major features of that society."

World Health Forum : Medicine and Health 1980, (1.2)  
p.124.

McDermott, Walsh. "Medicine, the public good and one's own".

"It is the poverty in underdeveloped countries, and the consequent rapid growth of population, inadequate nutrition, and crowded and insanitary living conditions that are at the root of the health problems..."

(World Bank, February, 1980: Health, Sector Policy Paper. p.20).

(i) THE CONTEXT

The earlier chapters above dealt at length with the historical origins of the economic and social inequalities which were brought about and reinforced over the years by the exercise of political power by the white minority population. The majority of the African population in the rural areas were driven deeper into poverty which led to ill-health for which minimal health facilities were provided. The small white population, which consolidated its political power through UDI in 1965, was concentrated mostly in the urban areas where it enjoyed 'better health and received the best care'.<sup>1</sup>

In this chapter the principal determinants of health and the extent of the inequalities between social groups in the country are examined. It is intended to bring-out the role of economic and socio-political factors in influencing - if not bringing about, the wide differentials in health status between the whites and blacks, the urban and rural populations, the modern and the peasant sectors. The nature of the disease conditions which are prevalent in the different population groups are examined and the causal links established, to lay the foundation for corrective action. The major health problems that afflict the majority of the population are examined in the context of the factors affecting inequalities within the society.

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1. Ministry of Health Sectoral Review, Zimbabwe, 1981.



The effects on the health status of previously vibrant communities resulting from; the disequilibrium created by capital penetration on a backward nation and the role of international capitalism in underdeveloping a country within the periphery of capital, are viewed. The thesis is put forward that health problems were the result of a proliferation of inequalities - economic, political and social - across the sectors which accumulated over time but whose magnitude reached crisis levels at the peak of the war; thereby requiring a new mode of planning for their resolution. This will form the basis for the specified health sector assessment and the proposal to employ a politically based, both objective and subjective oriented method, for formulating strategy decisions in the planning and management of health for development; which is the subject of chapters to follow.

(ii) ENVIRONMENTAL FACTORS

The effects of geographical and climatic conditions on health requires a brief explanation. Melvin House defined disease, the adverse of health, as lack of harmony of maladaptation to environmental conditions. The conditions referred to here can be related to hazards or stimuli of: the physical environment (atmosphere, water or soil); the biological environment (viruses, bacteria) and the socio-cultural environment (distribution, demography, nutrition, housing, customs or one's occupation). The interaction of these on the health of a community is diagrammatically shown on Table 5.1. It follows from this triangular relationship that no study of health is complete without a corresponding study of the geography of the country under consideration. The assessment of prevalent climatic conditions, relief and topography which influence the contraction, spread and nature of the diseases that afflict a nation becomes an unavoidable step in the analysis of the health problems of a society.

Since Zimbabwe is wholly within the tropics, the four seasons summer, autumn, winter and spring are clearly distinguishable. In Map 1.2 the relief of the country is shown, and in Table 1.3 is shown the detailed regional classification, relief and climatic conditions. Whereas the effects of these on agricultural output and other production levels of the different social groupings will

DIAGRAM 5.1

TRIANGLE OF CAUSAL RELATIONSHIPS BETWEEN THE STATE OF HEALTH  
OF A COMMUNITY, ITS ENVIRONMENT AND MATERIAL RESOURCES  
AS WELL AS BIOLOGICAL, SOCIAL AND CULTURAL CHARACTERISTICS



Source: Kark, S.L.  
EPIDEMIOLOGY AND COMMUNITY MEDICINE



be discussed later, here it is intended to point out their influence on the inequality in disease incidence and prevalence among the country's social groupings. The disease and human settlement pattern, is closely linked to them. The major areas of inequalities between the two racial groupings and between the two sectors of the economy (ie modern and peasant) are in addition closely related to the features identified under the environmental conditions affecting health problems.

Geographical variations in Zimbabwe lie at the root of the problems of land distribution and the overcrowding that is the normal feature of the TTLs, which is discussed extensively below. The highveld, which is more than 4,000 feet above sea level, and the Eastern highlands which are up to 8,000 feet, constitute the best farming land with the best temperatures - cool and mild - and the best rainfall. They have all the conditions conducive to good health and to good and varied food production. This region is predominantly inhabited by Europeans, the only African residents are workers in industry, mining or farming. All the major cities and towns are sited along this region. The lowveld, in contrast is below 3000 feet, hot and unbearable in summer, with low rainfall and a rugged terrain. The middleveld is a thin belt between the two with a mixture of both. Clean water supply and safe waste disposal are associated with these seasonal and climatic variations; the spread of intestinal and diarrhoeal diseases increases in the dry, hot, low-lying parts of the country which depend on unsafe surface water from the streams.

It is in the lowveld and at the fringes of the middleveld that most of the TTLs are located. The regions are currently unfit for habitation and cultivation.<sup>1</sup> It is here that malaria, schistosomiasis and sleeping-sickness are rampant. In the South-East of the country, where Triangle and Hippo Valley Estates were established with their expansive irrigation schemes watered by the Kyle, Bangala and Manjerenje dams, the artificial environmental changes imposed by economic requirements, distabilised the previous equilibrium with nature. As a consequence the vector borne diseases noted above and other forms of water borne diseases increased rapidly since the schemes were not accompanied by an increase in disease and environmental control measures, to restore the balance. The workers in these schemes became exposed to higher than normal risks of water borne diseases without being accorded higher levels of health care provision.

The pursuit of purely economic goals, in these geographic and climatic conditions is clearly demonstrated to put a large population at risk. Those who derive the most benefit, from the adverse effects, ie the owners of the estates - mainly multinational corporations, remain unaffected in the metropolis. The deterioration in health that follows the disease leads, as we saw in earlier

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1. The discussion below, on the Land Question, identifies the regions - bioclimatic and geo-physical, which are closely related to the division by altitude and relief.

discussions, to loss of work and the income therefrom and the result that, the local population fall into poverty, ill-health and helplessness. During treatment, the loss of workdays by a sizeable number of the workforce means a fall in output and productivity levels. The adverse effects of climatic factors on the economy and on the health of the individuals and the community are only too clear. It is invariably the workers and their families that suffer most from the loss in income and their families that suffer most from the loss in income and the consequent fall in the whole family's health status as a result of low food intakes, malnutrition and low resistance to further infection. Given the peasant's rural conditions the whole community may be affected by the infection.

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Geographical factors as will be examined further in Chapter VI, affect the location, distribution, supervision, accessibility and supply of drugs to health care facilities. Their effect on the country's infrastructure - road and rail network - which is important for food distribution and monitoring the country's health state, is viewed below.



(iii) POPULATION: DISTRIBUTION AND STRUCTURE

The distribution of population as a factor that has an effect or influence on the health status of the population needs to be examined in close association with the preceding section on geographical factors. The racial distinction in the settlement pattern (whose origins were discussed in Chapter I) demonstrates the deep levels of unequal access to the country's best farmlands and the climatically most habitable parts. If the distribution is viewed together with the country's regional differences, then a clear picture emerges of the level of agricultural productivity which can be expected and consequently of the availability of food with its effects on the health status of the population. For the sake of completeness, the location of the major urban centres where the most important activity is concentrated also need to be assessed.

In Map 5.3 the distribution of the European populations is shown. This is heavily concentrated on the highveld and the Eastern highlands with their cool and warm temperatures, good rainfall and black and red agricultural soil belts. This is also where all the major cities and towns are sited. In 1974, of the total white population 82 per cent lived in urban areas as against 16 per cent of the African population. Of the total white urban population, 55.3 per cent live in Salisbury and 26.3 per cent in Bulawayo; so 81.6 per cent of the total urban population (white) lives in these two main cities - leaving

MAP 5.3: THE DISTRIBUTION OF MUSLIM POPULATION.



the other 13 smaller centres to share the remaining 18.4 per cent. This in effect means that most modern sector activities are concentrated in these two centres. The remaining 18 per cent of the white population is rural and occupies large tracts of land in the commercial farming areas. Though scattered, rural and small, the population is well served by rail and road networks which reinforce the already existing inequalities of access to service centres, markets and secondary health care. Further analysis shows that 36 per cent of European land is within ten miles of a station or siding and only 6 per cent is more than 50 miles from a rail line or an all-weather road. The European population, in addition to being located in the best climatic regions of the country is clearly well served with transport facilities thereby improving their accessibility to services in time of need. The advantages of good communication in the spread of education for health improvement are only too well known.

In Map 5.4 the distribution of the African population is shown. This is concentrated in the low-veld and parts of the middleveld. If read in conjunction with Map 5.5 (malaria distribution) the full implications on health status of: population distribution, density and composition coupled with climatic and geographic conditions; become clearer.

With only 5 per cent of African Areas (TTLs and APAs<sup>1</sup>)

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1. TTLs - Tribal Trust Lands or former Native Reserves.  
APAs - African Purchase Areas.



#### MAP 5.4: THE DISTRIBUTION OF AFRICAN POPULATION.

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Illustration removed for copyright restrictions

within 10 miles of the railway, and 40 per cent more than 50 miles from the railway; leaving seasonal roads and bush tracks as the means of communication, the majority of the African population is virtually abandoned to a permanent state of ill-health. Exclusion from the health education programmes because of inaccessibility makes their condition worse. In 1974, 84 per cent of the African population lived in the African rural areas and the commercial rural areas. The former were located far from any urban centre, with 35 per cent of the areas over 100 miles from the nearest town. The population of these areas stand little chance of benefitting from economic advances through improved health levels, because they remain inaccessible. The level of population densities in the TTLs and the dangers therein to health are discussed below where it is shown that the combined effects on health of bad geographic location and climatic factors and high population density, led to low productivity and poverty with grave adverse consequences on health.

In Table 5.6 the broad distribution of the African population is shown as at the last census (1969). This includes the African population in the commercial farms, in the European areas. The Riddell Commission (1981) estimated that there were 1.5 million Africans in these farms, so the proportion of the African rural population remains high. The escalation of the war led to two major developments which are bound to affect the new directions and emphases in planning. The first was the growth of shanty towns, slums and protected villages.

The other was the flight of many families into neighbouring countries as refugees, from the Rhodesian regime's reprisals for their support of the liberation forces. The outflow of the young men and women to join the forces affected the population composition more than the pattern of distribution. The return of these groups into the country is bound to affect the distribution for they will not be willing to return to the previously unbearable TTLs. The designation of new resettlement areas in less crowded and more habitable regions holds prospects for improving the health status of the rural populations. Combined with other political and economic measures, this can result in the narrowing of inequalities of access to good and inadequate land between the races and the narrowing of income gaps within the modern wage sector and between it and the peasant sector.

Finally one observes that the concentration of the African population in the low lying areas increases the difficulty of ensuring clean and sufficient water supply and good sanitation.

Of the total African population estimated to be 7.23 million, 55 per cent was estimated to be under the age of 15.<sup>1</sup> Approximately 20 per cent of this is under 5 years.

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1. Annual Economic Review of Zimbabwe, August 1981. A working paper for the Health Sector Review ("The existing situation") 1981, quoted the size of the primary school going age group ages 5-14 years to be 2.112 million.



Eighty per cent of the children are in the crowded TTL's. In Table 5.6 it is shown that women form a higher percentage of the population in the TTLs than men, 67 per cent as against 33%. Mitchell (1961) observed that about 80 per cent of all males aged 20 to 34 years and 50 per cent of all males aged 35 to 39 years were absent from the TTLs in that year. In the commercial farming areas and the mining centres there is a high proportion of men - 288 men to 100 women in the North-East (G. Kay 1970) because of the distortion caused by migrant workers who form about 7.5 per cent of the population. Urban influx regulations also led to the two to one ratio of men to women in the urban areas. A further and more permanent feature was the departure of thousands of young people to join the armed struggle. Estimates at the peak of the liberation war were put at 33 per cent of those aged between 16 and 25 years. With the attainment of independence, these young people have to be absorbed into the modern sector which in most cases means that they will be urban dwellers.

Clearly therefore, we have in the TTLs a high proportion of the population which is both unproductive and highly susceptible to disease. The old, young mothers of child bearing age and children are left to face the harsh conditions of the rural areas while the able bodied struggle to make a living on low incomes in the modern sector. Of necessity, families are split with the accompanying economic and social consequences on health status. The unavailability of accurate statistics on

split families and levels of support between the modern and rural sectors add to the problems of efficient resource allocation in planning for health provision. The following groupings are however identifiable:

- (a) the ordinary TTL residents and APA farmers
- (b) those resident in the TTLs but involved in the money economy - self-employed farmers, tradesmen, teachers, health workers, extension officers, etc.
- (c) those who migrate between the money economy and the TTLs.
- (d) the town and city dwellers
- (e) cultural and tribal sub-divisions cut across the four above.

A look at the European population on the other hand shows that it displays all the characteristics of an advanced nation with a low birthrate of 12 per 1000 in 1980 and a rate of population increase of 3 per 1000 which has been deprecated by the white politicians.<sup>1</sup> The proportion of children under 15 is about 30 per cent of the population and old people constitute a sizeable percentage: the result of high living standards is a longer lifespan. These differences in population composition are important

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1. An extract from the Secretary for Health report 1964, said that "the fall in the European birth rate over the last ten years is not only puzzling but is also to be deprecated". Of the African population the same report in 1970 noted that, "the propensity to procreate is a feature of primitive people".

in the assessment of the population groups at risk which require the development and implementation of support programmes. Whereas the majority of the African rural population would require maternal and child care programmes, the white urban population would demand old people's homes and geriatric care facilities. With life expectancy at birth differences so wide - Africans 47 years and whites 65 plus, the understanding of differences in population structure would definitely lead to changes in policy emphasis across all the sectors. The health status inequalities discussed below are the consequences of the differences in population composition when viewed in conjunction with other economic, social and political factors.

(iv) THE LAND QUESTION: INCOME LEVELS, SOCIAL AND HEALTH INEQUALITIES

- (a) Land: Nowhere are the economic, social and political inequalities more pronounced than in the distribution of land and yet as Riddell (1978) observed,

"it plays a dominant role in people's lives<sup>1</sup>; over over 80 per cent of the population live directly off the land",

its mode of allocation, availability fertility are key

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1. "The Land Problem in Rhodesia. Alternatives for the Future". Mambo Occasional Papers, 11, 1978.



determinants of the level of poverty of the majority of the population.

The Land Tenure Act 1969 conclusively sealed the inequitable distribution of land and its classification under racial groupings. The powerful white agrarian rural national bourgeoisie had thrown out the liberal white politicians in favour of the right wing Rhodesia Front which had promised (and delivered through UDI, 1965) the return to white supremacy and domination. This meant curbing the expansion of the black petty bourgeoisie which was purchasing land formerly exclusively white under the policies of racial partnership advocated by Todd and Whitehead's administrations. The fear that this group could expand and once they had landed interests would compete with whites politically and economically in agriculture, thereby exercising a lot of power, led to the pressure to have an even more restrictive land policy. Under it, African Reserves isolated and surrounded by commercial farming land or those TTLs which had rich red soils were declared European land or 'islands', from which the Africans had to be forcibly moved.<sup>1</sup> Table 5.7 shows the classification of land by race. It is important to note that Urban Areas, except African townships, were

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1. The case of the Tangwena people in the East who had their homes bulldozed and who after losing a series of legal battles crossed into Mozambique; and that of Chief Ruya near Umvuma forcibly moved to the dry, hot, tse-tse and malaria infested Gokwe and Silobela.

TABLE 5.7

CLASSIFICATION OF LAND BY RACE (LAND TENURE ACT, 1969)

CLASSIFICATION	ACRES (millions)	% OF TOTAL AREA	% OF POPULATION
AFRICAN	45.2	46.8	96.0
EUROPEAN	44.9	46.6	4.0
NATIONAL	6.4	6.6	-
TOTAL	96.5	100.0	100.0

TABLE 5.9

RURAL POPULATION DENSITIES, 1969 & 1976

LAND CATEGORIES	POPULATION DENSITIES: ACRES PER PERSON	
	1969	1976
AFRICAN LAND (TTL&APA)	14.3	9.9
EUROPEAN FARMING LAND	40.2	34.4
EUROPEANS (only in European Farming Land)	1272.8	1208.9
TOTAL RURAL LAND	20.4	14.7

TABLE 5.8

DISTRIBUTION OF NATURAL FARMING REGIONS BY RACIAL LAND CATEGORIES, 1977

NATURAL FARMING REGIONS						
I	II	III	IV	V	X	TOTAL
Total Area ('000 acres):						
1515.3	18144.7	16938.6	32147.8	25423.0	3015.0	97184.4
Natural Region as %age of Total Area:						
1.6	18.7	17.4	33.1	26.1	3.1	100
European Land Area:						
1075.9	12519.8	7622.4	9001.4	6610.1	60.3	36889.8
European Land Area as %age of Region:						
71	69	45	28	26	2	
%age of Total European Land Area:						
2.9	33.9	20.7	24.4	17.9	0.2	100
African Land Area:						
197.0	4536.2	7283.6	17359.8	12965.7	1628.1	43970.4
African Land Area as %age of Region:						
13	25	43	54	51	54	
%age of Total African Land Area:						
0.4	10.3	16.6	39.5	29.5	3.7	100
%age of National Land:						
16	6	12	18	23	44	

Source: Riddell, R.C.

"THE LAND PROBLEM IN RHODESIA: ALTERNATIVES FOR THE FUTURE"  
 Mambo Occasional Papers, Socio-Economic Series No. 11 (1978)



designated European areas. The table shows that land was divided equally between the Africans, who formed 96 per cent of the population and whites who formed 4 per cent of the population. More precisely, the African rural population which is 84 per cent of total African population (or 80% of total country population), got 46.8 per cent of total land available, while the white rural population which is 18 per cent of total white population (or 0.72 per cent of total country population) got 46.6 per cent of total land.<sup>1</sup>

Tables 5.6 and 5.9 show the minimal changes, legalistic in nature, introduced under the 1977 Amendment to the Land Tenure Act which was meant to remove discrimination. Of the 82.2 million acres (85% of the land total) set aside for farming purposes, 47 per cent was reserved for Europeans and 53 per cent for Africans. The European land carries far less population and is more fertile, as the natural regions show, with most of it in I-II productive farming regions. Whereas 57 per cent of European land lies in these regions, a mere 7.3 per cent of African land lies here. The table shows that 73 per cent of African land lies in regions IV-X which according to Vincent and Thomas (1960) should not be used for crop production. Walker (1976) writes that under the

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1. "The Rhodesian Health Service - A Conceptual Model for Zimbabwe", an unpublished MSc Thesis, University of Aston, Birmingham. N.O.Mugwagwa, p.11, 1978.

provisions of the Land Husbandry Act, which laid the basis of standard landholding units in the TTLs, a single cultivator in regions I-III required 68 to 80 acres, in region IV 160 acres and 390 acres in region V.<sup>1</sup> The total population carrying capacity of the TTLs, given their present size and geographic location, was put at 280,000 families. J.D. Jordan (1979) estimated that the peasant sector, including provision for irrigated plots, should be carrying only 325000 farming units.<sup>2</sup>

The Riddell Commission (para 282, 1981) summed up the existing situation in 1980 thus:

"The carrying capacity of peasant occupied land has been stretched to limits which make neither ecological nor economic sense."

The peasant land had exceeded its carrying capacity in 1977 by 2.5 times, with 675000 family units on it. In numbers, this amounted to an excess of two and a half million people. By 1980, the number of peasant households had reached nearly 800,000.

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1. Riddell, RC (1978) p.41 notes that the Land Husbandry Act holding allocations do not coincide with Vincent and Thomas' rainfall criteria for the Natural Farming Regions which means that the assumptions used lead to a higher estimation of the TTLs carrying capacity.
  2. Jordan, JD "The Land Question in Zimbabwe", Zimbabwe Journal of Economics, I(3) 1979. Quoted in Riddell Commission, June 1981. p.58.



"Pressure for land has become such that soil conservation has been heavily discounted by people struggling to eke out a living: over 17 times too much land is currently being used for arable cultivation; this land has been taken from grazing land, half of which is<sup>1</sup> either completely bare or heavily over-grazed."

The combination of inadequate densely populated, poor quality land and inconsistent government policy plunged thousands of black rural families into poverty. Not enough food to feed themselves was being produced let alone for sale to raise some money to pay for school fees and attendance at clinics or hospitals.

Cross (1977) wrote that in 1962 the estimated availability of maize in the tribal areas was 160kg per capita, by 1977, it had fallen to 105... well below the national consumption figures which at present range around 175kg per capita.<sup>2</sup> The people accepted a steady fall in the level of nutrition up to 1970, but from that date, they began to actually import food to make up for the rural shortfall. Low levels of food consumption lead to nutritional deficiencies which in turn increase the severity and frequency of infections, and are themselves aggravated by infections. A form of vicious circle

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1. Riddell, R. "Zimbabwe's Land Problem: The Central Issue", From Rhodesia to Zimbabwe, Morris-Jones W.H. (ed.) Frank Cass. 1980 Quoted in Report of the Commission of Enquiry into Incomes, Prices and Conditions of Service, June 1981.
  2. Cross, E.G. "The Tribal Trust Lands in Transition: The Policy Implications", (Zimbabwe) Science News, 11, (8) August 1977.



develops which is mostly evident in young children and is debilitating to girls who are the future mothers.

Dr A J B Hughes observed that,

"... in one TTL, between two-thirds and three-quarters of the families did not produce enough food to satisfy their own needs, approximately one-third had no cattle; and a high proportion did not possess adequate agricultural implements".<sup>1</sup>

This situation was exacerbated by government action which imposed curfews of up to twenty-two hours a day and rounded up the peasant population into 'keeps' or so called 'protected villages', at the peak of the liberation war. In 1978, many cases of peasant crops being destroyed by defoliants used by the Smith regime forces were cited and impounding of community livestock as punishment for supporting the insurgents, was commonplace.

By comparison, the commercial farmers were having a field day. Gross operating profits for white farmers rose from \$35.2 million in 1965 to \$109.5 million in 1974. By 1978, commercial agriculture accounted for 40 per cent of foreign exchange earnings! The state played an active role in perpetuating these inequalities. Through a combination of measures ranging from: lack of infrastructure in the form of rail and road service, underpricing of peasant produce, lack of credit facilities and direct taxation; the state

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1. Quoted in Mugwagwa, N.O.(1978) Thesis Chapter III p.14.

facilitated the flow of surplus value from the peasant to the modern sector, it ensured that the impoverished peasants subsidised the rich modern sector and thereby; in addition to widening the inequality gap between the whites and blacks, the peasant rural sector and the urban sector; underdeveloped the majority of the rural African population. The subsistence sector's inability to provide for the basic needs of individual families means that the father and other members have to offer their labour at a price lower than the cost of reproduction of themselves and their families. Capital therefore does not have to pay for labour reproduction. Capitalist development has therefore been dependent not only upon the under-development of the TTLs, but also upon land policies in the rest of the economy.

"Non-ownership of land in the urban areas has ensured continued links with the TTLs and prevented the increase in wages necessary to create a permanent African labour population".<sup>1</sup>

Land policy affected the rest of the sectors.

The result of the above has been excessive overcrowding in the TTLs, coupled with abject poverty and an oversupply of cheap labour flowing into the modern sector; side by side with an oversupply of land, abundant wealth and high levels of health. The economic motivations of land

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1. Riddell (1978) p.3.

grabbing and surplus labour creation for the mines, farms and industry; coupled with the political action which legitimated it over the years and forced the Africans more and more into crowded, inhospitable and unproductive reserves - a process of peasantisation and prolitarianisation of the Africans - led to a state of poverty, squalor, want, hopelessness and helplessness; a state of ill-health (in the midst of over-abundance) for the rural African population, unprecedented in Black Africa. Land issues had sparked off the 'Risings' at the close of the 19th century, they fuelled the liberation war in the 1970's. The conflict between the whites and blacks was a fight for survival for the later and a fight to retain inequitous privilege for the former, which could only be resolved by armed confrontation.

(b) Income Levels

Further levels and forms of inequality are identifiable in other sectors and spheres of social activity. The Riddell Commission (1981, para.288) noted that:

"The paucity of official statistics on income levels in the peasant economy is alarming and, taken in conjunction with the state of affairs as observed ... on the ground, serves as the most telling comment on the neglected status that this sector has suffered in past policy approaches".

Table 6.0 shows the differences in family income between the races and between the blacks in the formal and peasant sectors. The Ministry of Health Sector Review



TABLE 5.10

FAMILY INCOMES, 1979

POPULATION SUB-GROUPS	MEAN ANNUAL INCOMES (in dollars)	RATIO OF INCOMES
WHITE, ASIAN, COLOURED	8500	39
BLACKS IN FORMAL SECTOR	1150	5
PEASANT FARMERS	220	1

Source: Derived from THE RIDDELL COMMISSION (1981) and  
quoted in the HEALTH SECTOR REVIEW (MINISTRY OF HEALTH), 1981

(1981)<sup>1</sup> noted that the figures in Table 6.0 on mean family income for the non-African population and the urban blacks in formal employment, underestimated the income where there is more than one wage-earner in a household. The question of determining the average income for peasant farmers is a difficult one although \$220 per annum is estimated. In two provinces (Midlands and Mashonaland) the Riddell Commission (1981)<sup>2</sup> found a wide range of earnings in cash and kind from \$80 per annum per peasant farmer in Lower Gwelo, to \$247 per annum per peasant farmer in Wedga. In the same areas, commercial farmers in former purchase lands in Lower Gwelo had incomes ranging from \$820 to \$4200 per annum. This illustrates among other things that land availability coupled with provision of support services can make a big difference in income levels. It can be safely stated that the ratio 39:5:1, high as it is, understates the extent of the income inequalities.

The most inequitable practice within the system or the Rhodesian state was the subsidisation, in addition to all the burdens mentioned above, of the modern economy, urban

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1. The Health Sector Review (1981) was an exercise undertaken from 1980-81, after Independence, in whose design and execution I played an active role as Special Assistant to the then Minister of Health, Dr H S M Ushewokunze and later as a Senior Official of the Ministry of Health. It aimed at laying the basis and providing the substance for the Government's health policy and was financed by SIDA (Swedish International Development Agency).
  2. The Report of the Commission of Inquiry into Services, Prices and Conditions of Service, June 1981, Chairman R.C. Riddell (referred to as the Riddell Commission) p.59.

based as well as rural, by the impoverished rural peasant sector. The provision to Commercial farmers, of heavy government subsidies, paid out of treasury funds to which peasants contribute constitutes one of the largest elements of peasant subsidy. Between 1973 and 1975 a total of \$55.3 million was spent on subsidies, losses by and assistance to Commercial farmers, which worked out at about \$8000 per farmer. In 1977 \$24 million was spent on white farmers and a mere \$6 million on the African Purchase Area farmers, with nothing paid to the peasant sector. If one adds the fact that less is paid for peasant produce already disadvantaged by poor access to markets in urban areas; lack of social security for the unemployed who have to be absorbed by the peasant rural sector; costs of labour reproduction (since low wages do not cover the costs of maintaining worker families); the intolerable size of the burden of the rural poor becomes evident. Is it any wonder therefore that the poor are and will remain poor? The success of the whites' strategy devised and implemented over time, to underdevelop the rural population, becomes clearer. The place of international capital, as represented by the Transnational corporations, solid support for the national bourgeoisie, is also only too evident. A move towards equity in health, can only be made through applying a planning strategy that de-emphasises the costs and benefits factors in favour of concentration on political and attitudinal factors so as to restore the social balance which is necessary for health improvements and equality of access.



Inequality of access to wealth in the industrial sector is just as wide. Only two of the 56 companies quoted on the Stock Exchange having, of the top 10 shareholders, ownership of less than 50 per cent of the shares; overall approximately 75 per cent of the shares were foreign owned.<sup>1</sup> The role of international capital was discussed in Chapter III. Its increased support for the regime after UDI complicated the resolution of the conflict in Zimbabwe. With the Western countries therefore indirectly and passively supporting UDI, because of the need for continued surplus extraction, it became difficult to resolve the conflict without involving the international community and its politics. The quest for national development becomes inextricably linked with the quest for equity in health and political and economic freedom - problems which all countries within the periphery of international capitalism experience.

The abysmally low average per capita income from peasant production suggests that many people cannot survive on incomes from their own production alone. With more than 50 per cent of the population either too young or too old to work for themselves full time, 25 per cent of the working population (1979/80), is noted to depend for their livelihood on wage incomes.<sup>2</sup> The absence of social

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1. Ministry of Health - Sector Review, 1981 p.12.

2. Mugwagwa, N.O. (1978) Unpublished MSc Thesis, University of Aston, quotes the percentage of African population employed in 1958 as 19.2%, 1965 as 15.4%, 1973 as 15.5% and 1976 as 14.6%. The figure for 1980 went up because of the Independence and high economic growth rate which followed.

security payments and the inextricable links between the formal sector and the peasant and informal sectors, means that a much larger proportion of the population's living standards is influenced by the level of wage rates. The Riddell Commission (1981) put a figure of 'at least 50 per cent and probably as much as 75 per cent of the people of Zimbabwe have become dependent to some extent on the wage system'. (para.269).

What then is the size of the low income earning group? Again, the problem of available statistics and the form in which they are presented limits the analysis which can be undertaken to bring out inadequacies and inequalities between and within groups. Up to 1981, figures on average earnings were presented by social grouping including the employment levels. This practice of racial differentiation has been discontinued now, so the Annual Economic Survey of Zimbabwe gives combined figures which hide differences (see Appendix). A good illustration is the fact that of the 232140 workers paid less than \$30 cash in 1977, 206930 of them ie 89 per cent, received less than \$20.<sup>1</sup> In Table 5.12 I show the number of African workers in all sectors earning over \$200 per month which amounts to 9900 or 1.2 per cent of the total African workforce or 0.98 of the total including whites. In Table 5.13 the

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1. Report of the Commission of Inquiry into Incomes, Prices and Conditions of Service, June 1981, para.274(c) (The Riddell Commission).





number of African workers earning less than \$200 per month is shown. These comprise 98.8 per cent of Africans employed or 80 per cent of all employed in formal sector. Variations between sectors are also shown for different earnings groups.

Although the above figures are for 1977 the picture they present is a fair representation of the situation at the time of independence in 1980. By December 1979, the number of people engaged in formal employment was 991000. This indicates a modern sector absorption of 40 per cent of the total African labour force of 2.5 million. This figure leaves 1.5 million employable people either in the peasant sector, in the informal sector, partially employed or unemployed. Paul Ellman (1978)<sup>1</sup> estimated that 60000 - 80000 new jobs a year will have to be created simply to keep pace with the growth in population of 3.6 per cent annually. The number of the jobless Africans in that year was shown to be increasing at an average of 1000 a month. Since 1974 there had been a shortfall of about 250000 in the creation of new jobs; compared with what was needed to avoid an increase in unemployment. The Zimcord Document (1981)<sup>2</sup> estimated that 85000 new jobs could be created each year in the modern sectors if the economy expanded at the optimistic rate in real terms of

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1. Ellman, Paul. "A Meagre Economic Inheritance for Zimbabwe", The Financial Times, 11th April 1978.
  2. Zimcord - Zimbabwe Conference on Reconstruction and Development held in 1981, Salisbury. p.48.



8 per cent a year. The Riddell Commission went on to assess that with 175000 additions to the labour market from annual population increase if 75 per cent of them seek employment, a shortfall of 50000 jobs a year in the modern sector will be recorded. This will constitute the annual additional burden on the peasant sector or the informal sector or the unemployed, thereby dragging considerably more families into poverty.

The Poverty Datum Line is defined, as the income required to satisfy the minimum necessary consumption needs of a family of a given size and composition within a defined environment in a condition of basic physical health and social decency. By definition, those families with incomes lower than the PDL, are living in poverty.<sup>1</sup> It is however considered to understate the level because of its exclusion of items as 'luxuries' but which people purchase to be socially decent - like beer, tobacco, newspapers, radio. Table 5.14 gives the estimated PDL urban incomes for an average family of six for the selected three urban areas in December 1980.

The average PDL estimate of \$128 allows for the change in government's policy in 1980 which removed primary school fees and provided for free health services for those earning less than \$150 per month. If the government

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1. Riddell Commission, 1981. p.80-81, paragraph 360.



TABLE 5.14

ESTIMATED URBAN DATUM LINE INCOMES FOR A FAMILY OF SIX, DECEMBER 1980  
(IN DOLLARS PER MONTH)

CODE	SALISBURY	BULAWAYO	FORT VICTORIA
G	126.14	131.46	117.62
H	132.93	138.33	124.65

- Note: - There is an average of 128 dollars per month
- G: A family consisting of a man and woman, an infant, a boy (5-8 years), a girl (11-12 years) and a boy (13-14 years)
  - H: A family consisting of a man and woman, a girl (5-8) years, a boy (9-12 years), a girl (13-17 years) and a boy (15-18 years)

Source: 1. RIDDELL COMMISSION (1981), p. 81  
Zimbabwe Monthly Digest of Statistics, January 1981

2. Cubbit, V.S.  
SUPPLEMENT TO THE URBAN POVERTY DATUM LINE IN RHODESIA:  
A STUDY OF THE MINIMUM CONSUMPTION NEEDS OF FAMILIES, 1974  
Faculty of Social Studies, University of Zimbabwe,  
1979, p. 58

stipulated minimum wage of \$85 from January 1981 in Commerce and Industry is used, this sum is below the PDL by \$43. Two additional factors make the position of the workers deplorable. Firstly, the new minimum wage requirement compares very badly with what is actually being paid to workers. In fact a number of workers lost their jobs as a result of its imposition thereby making it unpopular among employers and low income earning employees who will not disclose that they are being paid less for fear of losing their jobs.<sup>1</sup> Secondly, urban budget surveys of low income families indicate that over 92 per cent of household incomes derive from the income earner. The inextricable link between the urban income earners and the rural peasant population means that the modern sector has been taxing the peasant sector, on top of existing multifarious problems, therein, through payment for the labour input in modern sector production. It meets the costs of labour reproduction. In effect,

"the development of the modern sectors is built upon the<sub>2</sub>partial underdevelopment of the peasant sector.

In the final analysis, wage employment has not enabled thousands of households to escape from poverty. If this

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1. Herald 25.2.1982: The Minister of Labour and Social Services, aware that the minimum wage requirement was not being adhered to, gave employers until 28.2.1982 to comply or face stern government action.
  2. Riddell Commission, 1981, p.82, para 366.

situation is set against the inadequacies in housing and living conditions in urban areas, a depressing picture emerges. It is nevertheless much, much better than what exists on the farms and mines which historically provide appalling housing, living and working conditions alongside very low subsistence level wages.

(c) Social Inequalities:

The history of housing was set out in earlier chapters, where it was shown that the black working population's accommodation in Zimbabwe consisted of single quarters boarding hostels since they were supposed to come only for work and had to return to their rural homes in the Native Reserves at the end of their working lives. No permanency was envisaged here - an indication of the limited ascendancy of the 'migrant school' over the 'proletarian school'.<sup>1</sup>

The Land Apportionment Act was amended in 1941 to provide for the establishment of urban black townships. The accessibility to urban housing was linked to employment in the formal sector. The 1960 Vagrancy Act further empowered local authorities to send back to the TTLs people not gainfully employed or unregistered urban residents. The 1958 Urban Affairs Commission had reported that only an estimated 41 per cent of all formal sector employees was living in family units in towns. Often

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1. See the discussion in Chapter III, Section "Peasantization, Proletarianization and Conflict". Page 18.



allocation was made on the basis that the worker's salary was above a certain level. This was a clear sign of discrimination against the already grossly under-provided and low income urban families.

The size and magnitude of the housing problem and the risks to health in urban areas is not only due to poverty. Not only is there a high number of persons per housing unit, but the urban influx which accompanied the escalation of the liberation war brought 600000 people in and around towns to seek refuge.<sup>1</sup> Squatter camps, shanty towns and over-crowding arose which stretched the already limited piped water supply and sanitation facilities. Ideal conditions for the spread of communicable diseases were created which were exacerbated by the inadequacy of food supplies. Estimates put the surplus population in the towns at a two to three times the designated population. The Riddell Commission observed that,

"there is a wide range of very serious housing problems in Zimbabwe today. These include the very poor and frequently sub-human living conditions in which very many people are having to live - inadequate and cramped housing, lack of access to clean water and basic sanitation facilities and lack of ancillary services such as roads, street lighting, schools, clinics and recreational facilities - a shortage of finance with which to construct housing and associated services and an inability of the poor to pay for housing even if it were available".  
(1981, p. para ).

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1. Riddell Commission, 1981 p.209 para.953.

The examination of the level of housing shortages showed that in June 1980, the official waiting list totalled 44900 units throughout the country's urban centres.<sup>1</sup> Of this official total, 18400 was in respect of Salisbury and 10000 was in respect of Bulawayo. The actual need however is exceedingly higher than the above. A recent survey by Van der Schyff (1980 p.6.) indicates that population densities average nine people per dwelling unit and in some instances peak at 20 people or more. The Ministry of Local Government has planned a programme to build 167000 new units in five years which will go some way towards alleviating the overcrowding. The combination of this crowding and low income earnings had serious adverse effects on the health status of the populations concerned as the discussion below will show. By contrast the white suburban houses and flats provide comforts which are among the highest in the world!

Clearly the problems of rural development, employment generation and split families which lie at the root of poverty among the mass of the African population (in the midst of plenty), has a lot to do with the inability to provide adequate housing where the income earners live. Adequate provision of housing, clean water and sanitation accompanied by good wages would do much to improve the health of the urban dwellers and to narrow the gap between them and the white section of the population.

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1. See Appendix for Urban Centres, their population and housing units.



The situation in the commercial farming areas and the mines, who employ the largest number of African workers, historically leaves a lot to be desired. Surveys in these places have disclosed appalling living conditions and accompanying ill-health and malnutrition. With the minimum wage for farm workers at \$30 per month excluding food and accommodation, which represents a significant rise from the \$17 paid in 1972, the level of rations has suffered tremendously. A survey carried out in Bindura in 1980, showed that a family of six needed a minimum cash wage of \$80 a month. This represents a cash wage increase of 167 per cent over the minimum wage; assuming that housing, education, health and food rations remain free. For mining employees a figure of \$98 a month compared to the present minimum of \$58 was arrived at. It can be concluded that after adding the many unemployed who have to depend on relatives and friends also on very low minimum wages, the poverty of many families in the rural areas results in many more families in the modern sector being drawn into poverty. In the final analysis the gap between the rich and the poor is very wide indeed in Zimbabwe.

(d) INEQUALITIES IN EDUCATION

One way of escaping being caught in this poverty vicious circle is through education which provides the opportunity for upward class mobility. Skilled training, after acquisition of a reasonable educational standard, for recruitment into industry and commerce or other professions,



threatened the political and social power balance with the whites. The political structures set up in the 1930's had guaranteed the white worker classes that there would not be any competition from the blacks. Skilled, semi-skilled and artisan training was exclusively for Europeans. Africans were only to receive sufficient education for the worker level with a few allowed into higher education and skilled training. Inequalities in resources allocated to the two population groups are best illustrated by expenditure levels. In 1975, approximately \$30 million was spent on the children of 300000 whites, Asians and coloureds. In 1976-77, whereas \$45.9 was spent on education per African pupil, \$531.0 was spent per European pupil. In the same year only 7840 black school leavers had any form of secondary education, which works at about one in every 900 black people. The whites position was 5146 school leavers with secondary education which is one per 50 of white population; working out at 18 times the rate for blacks.<sup>1</sup>

The position of the African population is made worse by a variety of other factors. Because most of its population is rural, accessibility to schools is not easy, which accounts for the high drop-out rate which leaves a mere 12 per cent of the pupils who enter Grade I to proceed to secondary education. There are no sufficient places

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1. Ministry of Health Sector Review (1981) p.12.

for those who may want to continue with further education. The rural areas are the most disadvantaged because the Government did not provide schools for them, a task left to missionaries and later assigned to local councils. The commercial farming areas were even worse-off, with their schools unregistered and the teachers often unqualified. With 1.5 million people in these areas the disadvantaged children are many. They have to pay for school attendance often up to Grade 3 only, through services on the farms. This applies in the majority of cases.

A national survey of literacy conducted in Zimbabwe in the mid 70's showed that: 26% of men received less than 3 years education as against 32 per cent of women; 9 per cent of men received secondary education as against 4 per cent of women.<sup>1</sup> Even the University of Zimbabwe, which purported to be multiracial had a black annual intake over the years of 41 per cent of the total. Figures shown in Appendix of medical students also tell their own story. These inequalities and deficiencies greatly impede health education and promotion effects which in turn affect individual and community development. Since independence, the government has removed one of the major obstacles to education which was the payment of fees. This has led to a doubling of school-entry figures which now top the million mark. With the closures which had

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1. Riddell Commission (1981) p.43.



ccurred at the peak of the war, a big backlog exists which is bound to strain the availability of teaching staff. Inevitably the poor student-staff and equipment ratios in African schools are expected to reach chronic levels. White schools have, under guises of community schools status, refused to allow increased black intakes even after independence, and thereby retaining the best in equipment and staff back-up.

The availability of education improves the community's level of awareness and its participation in social activities including in health. A link exists between the inadequacy of educational facilities and the poor health status for the majority African population. It remains imperative therefore that any permanent advances in health should be accompanied by advances in education.

(v) HEALTH INEQUALITIES AND HEALTH STATUS INDICATORS

The range of inequalities across the sectors between the whites and blacks, the urban and the rural areas have been examined and it was observed that they do manifest themselves in differential levels of health among the population. Among the disadvantaged African population it is the women and children who are most adversely affected by these resultant health problems. As we observed, most health problems are the result of poverty, especially inadequate food supplies, poor water supply and sanitation. Because of the special nutritional needs for growth, children are particularly vulnerable to



malnutrition which results from inadequate food supplies. The inability of the rural peasant population to produce enough to feed itself was examined together with the serious problems of low urban income earners. It is the intention here to show the extent of the effects of these deficiencies on health status of the vulnerable population groups.

On coming to power, the majority government of Zimbabwe had neither the manpower nor the infrastructure to establish the health situation in different parts of the country. It was however common knowledge that the war had led to a serious deterioration in health, especially of the African population. A national survey to assess the nutritional status of children aged 1-5 was therefore undertaken in September 1980.<sup>1</sup> This was carried out in the rural areas among the peasant population in the villages and at clinics. The detailed study is shown in appendix. The picture that emerged here was one of widespread and high prevalence of malnutrition and undernutrition. Of the surveyed 5000 children in the eight electoral provinces, nearly a third showed definite evidence of malnutrition and a further third had borderline malnutrition. The striking aspect was that higher rates

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1. As Special Assistant to the Minister of Health, I prepared and supervised this survey which took one month. I was also responsible for analysing the results in conjunction with UNICEF and support personnel not part of the Ministry of Health.

of malnutrition were found in the Provinces which had low food levels because of a multitude of disadvantages which we identified in the course of our discussion. Matabeleland North and South top the league with their dry climatic conditions, remote rural population, commercial farming and mining. Victoria Province, though it had reasonable food levels had problems of malnutrition due to population geographical distribution and accessibility, feeding habits, coupled with low government coverage in a variety of sectors. It also has the irrigation complexes and their accompanying problems of water and vector borne and related diseases.

Our earlier discussions also showed how closely the health pattern in commercial farms followed that in the rural areas. A study referred to earlier in the context of earnings levels (carried out by the University of Zimbabwe in December 1980 in Bindura), of 200 children under the age of 5 years in six large commercial farms; disclosed that a fifth to a half of the children showed definite evidence of undernutrition.<sup>1</sup> This was in a rich farming area and the most striking revelation is the fact that the farm owners believed that malnutrition among their employees' children was non-existent or negligible. In another health status survey in Matabeleland South districts of Beitbridge and Nyamandlovu, 112 children were examined from 10 commercial

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1. Quoted in Health Sector Review, November 1981, p.6.



farms<sup>1</sup>. The results showed 45 per cent malnutrition in Beitbridge and 38 per cent in Nyamandlovu. The poor mud and dagga housing conditions and overcrowding were also reported to present health hazards for the children.

The situation in the urban areas, though considerably better than in the rural areas, nevertheless is cause for concern.

"In Salisbury a 1980 survey by the City Health Department of over 33000 children in 48 suburban schools found that a quarter of Grade I pupils<sup>2</sup> showed clear evidence of malnutrition..."

In 1974, malnutrition was the fifth most commonly notified cause of death. It had moved to fourth place by 1976 accounting for 668 deaths. The problem of inadequate nutrition is compounded by rapid population growth which was estimated to be 3.6 per cent in Zimbabwe in 1980. Large family size and close spacing of births frequently preclude sufficient food and care for children. The World Bank (1976) noted that evidence of the correlation between malnutrition and large family size came from Nigeria, Thailand and India. Malnutrition also contributes to infectious diseases by impairing normal body response to disease, thereby reducing required

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1. This survey was conducted in July/August 1981 by the Provincial Medical Officer of Health Staff in Matabeleland, in conjunction with R Loewenson, University of Zimbabwe.
  2. Health Sector Review, Ministry of Health, 1981. p.6.



immunity. Conversely, disease can contribute to malnutrition. Epidemics of diarrhoeal diseases are often followed after a few weeks by outbreaks of nutritional diseases. Enteric infections are said to inhibit absorption of nutrients, thereby decreasing the intake required to maintain nutritional status.<sup>1</sup>

Clearly, the main causes of malnutrition are the inequalities in access to economic resources and low socio-political status for the majority black and rural populations; as discussed in the above sections. The effective - in terms of attaining and retaining a good health status - preventive and promotive measures will require political, social and economic means. The emphasis portrayed throughout this study on political factors is aimed at highlighting the fact that health problems in Zimbabwe are mainly of a distributional nature. This does not rule out the need for more better land for cultivation by many peasant farmers. This factor is aptly illustrated by the fact that in the 1980 to 1981 season, the country produced surplus maize for export of over two million tons but despite which malnutrition was prevalent in some parts of the country.

The 'medical' problem of malnutrition which is responsible for so much disease, suffering and death, is thus

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1. Mugwagwa, N.O. (1978) Chapter V p.9. MSc Thesis, "The Rhodesian Health Service - A Model for Zimbabwe". (Unpublished) University of Aston, Birmingham.

associated, in the experience of senior Public Health doctors, with low income and poor educational status, and is known to be most common during the crop growing season when food stores are lowest.

Cases of maternal malnutrition and infections during pregnancy with their accompanying complications at birth are most common among the African women in the rural areas. Whereas maternity provision is high in the big urban areas through baby clinics and the Central Hospital facilities,

"about a fifth of births in rural areas take place with institutional care, and even then often in very poor conditions. Few rural women receive adequate care in the antenatal period."<sup>1</sup>

Availability of statistics on African births and deaths is limited especially for the rural areas which are most affected. Urban data collection however is sufficiently accurate to enable racial comparison. In 1979, one maternal death was registered for the white population, as compared to 141 maternal deaths (excluding those related to abortion<sup>2</sup>) in black women.

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1. Health Sector Review, Ministry of Health (1981) p.8.
  2. It should however be kept in mind that these were high as is implied by the observation of the Secretary for Health in his 1972 report; "By far the most common cause of adult admissions to Central Hospitals is abortion, and there is little doubt that a very large proportion of such cases are self-induced either mechanically or by the use of medicaments".

In the 'closed' government maternity units the maternal mortality rate was as high as 145 per 100,000 total births. The still-birth rate was over three times the registered rate for whites.<sup>1</sup>

The effect of socio-economic factors on maternal health and maternal child care is most reflected in the infant and child mortality and morbidity rates. Whereas the registered IMR for whites was 14 in 1979, that for the black population was not readily available countrywide because of lack of registration of births and deaths. The European rate compares with that found in developing countries, which reflects their priveleged socio-economic position. To arrive at the black rates, a number of estimates have to be made. At the peak of the liberation war, the estimates were put at one in two live born babies died within twelve months of birth, taking into account the bombings and burning down of villages, massacres in refugee camps and deaths in 'protected villages'.<sup>2</sup> A crude estimate for the rural areas, calculated from United Nations figures for the mid 1970's gives an average IMR of about 140.

"The most deprived<sub>3</sub> districts possibly have up to 200 or more".

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1. Health Sector Review, Ministry of Health (1981) p.8.
  2. Dr H S M Ushewo Kunze, (et al) 1980  
"Behind and Towards a Health Model for Zimbabwe",  
Ministry of Health, Salisbury.
  3. Health Sector Review, p.9. 1981.



In the urban areas, although the black population is better provided than in the rural areas, by comparison with the non-black, their figures are very high. Black IMR was estimated to be over three times that of non-blacks in the city of Salisbury at between 30 and 50. Estimates for two small towns were put at between 50 and 90. In Figure 5.a it is shown that there is an inverse relationship between the income levels and the IMR - the lower the group's incomes; the higher the IMR and vice versa. It can be summarised that,

"per 1000 live births, for every white infant death, there are two to three among the city blacks, five among small town blacks,<sup>1</sup> and 10 on average, in the rural areas."

Differences in the child mortality rates between 1-5 years are even more marked because of the problems of child feeding following upon weaning. The low availability of food, poor hygiene and high levels of infections, put a big number of rural African children at risk. In 1979, the mortality among blacks in this age group was nearly 13 times that of non-blacks. Within the African population itself, rural mortality in this age group may be 30 times that of Salisbury non-black children. The magnitude of the problem is appreciated if one observes that among the Salisbury blacks, nearly 47 per cent of the total deaths in 1979 were under fives (14 per cent of that population group). In the same year,

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1. Health Sector Review, 1981, p.10.

of the total non-black deaths, just over 3 per cent were under fives (7% of that population). In the rural areas, twenty-five to thirty-three and a third per cent of the children born will die before their fifth birthday, as compared to only two per cent of the non-black population born in Salisbury.

(vi) DISEASE PATTERN

Comprehensive and reliable information on patterns of disease in the country is not yet available, as in most under-developed countries. What is available however relates mostly to hospital attendances with regard to the majority African population. Whereas European births and deaths are compulsorily registrable, no similar requirement exists for the African population. The possibility of obtaining indicative data from inspection of African schools has not been tried. Inspection is only limited to white schools where it has been compulsory from the 1920's. From the available statistics, the mass disease-pattern is one typical of an under-developed country, characterised by gross inequalities in health status. These inequalities are the result of parallel inequalities in wealth, income and opportunities. The major health problems resultant comprise of communicable (parasitic and infectious) and nutritional diseases.

The influence of the physical and biological environment noted earlier in the chapter is more pronounced in the

nature of diseases that affect the different communities. The absence of malaria and tse-tse fly from highlands accounts for the role of the natural physical environment on disease patterns; while the increase in schistosomiasis as a result of the expansion of irrigation schemes accounts for the role of human economic activity in the change in disease patterns. On the other hand, parasites that cause infections, are a part of the biological environment. This relationship between the environments extends to the cultural organisation of communities and their utilisation of traditional and modern medicines to alter or restore rural health conditions (Lenneiye, 1980). Cha anduka (1967) notes this cultural aspect when he discusses what level of illness is regarded as 'normal' and at what stage of illness, the family within a community, obtains herbs from family sources, then from a village herbalist and if the condition persists, from a senior traditional healer or a hospital.

Tarimo (1978)<sup>1</sup> identified three categories of communicable diseases prevalent in the Third World. These were listed as: Airborn Diseases - (measles, tuberculosis, pneumonia,..) faecally-transmitted (typhoid fever, dysentery, diarrhoea..), vector-borne diseases (malaria, bilharzia, trypanosomiasis).

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1. Tarimo, E. "Health and Self-Reliance; The Experience of Tanzania". Development Dialogue I, 1978 p.35.



Similar diseases predominate in Zimbabwe among the poor urban and most rural populations. In Table 6.4 is shown the principal factors of registered mortality by race and also the percentage of the total deaths by disease for selected years. In Table 6.5 is shown the notifiable infectious diseases and in Table 6.6 the principal factors of registered infant mortality for Africans. What comes out first is the way in which statistics have been kept under racial groupings. This has enabled the disparities between the two races to come out clearly. This however hides other differences in health status between the groups resident in urban and rural areas within the African population. Most child deaths in rural areas occur because of lack of basic sanitation and safe water supply. These facilitate the spread of preventable diseases whose synergistic effects with conditions of malnutrition among the poor, lead to high mortality rates. Muchenje (1980) noted a figure of approximately over 50 per cent of the deaths in some parts of Africa as being children under 5.<sup>1</sup>

Among the white population, it is the degenerative diseases that are the biggest cause of mortality. These are a feature of advanced countries and require sophisticated care. This accounts for the skewing of

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1. Muchenje, W.C. (1980) "The Potential Impact of Structural Factors on a Successful Implementation of Primary Health Care". A Thesis submitted for a D.P.H., University of Pittsburgh.

TABLE 5.15

## PRINCIPAL FACTORS OF REGISTERED MORTALITY

DISEASE	1979		1976		1965	
	No.	%	No.	%	No.	%
<u>AFRICANS</u>						
Measles	2010	10.2	577	4.3	462	5.2
Pneumonia	1767	9.0	1213	9.0	818 <sup>a</sup>	9.2
Enteritis & other diarrhoeal diseases	1220	6.2	712	5.3	501 <sup>b</sup>	5.6
Avitaminoses & other nutritional deficiencies	809	4.1	668	4.9	516	5.8
Other causes of perinatal morbidity and mortality	747	3.8	655	4.8	656 <sup>c</sup>	7.3
Motor vehicle accidents	679	3.4	577	4.3	239	2.7
Malignant Neoplasm	591	3.0	448	3.3	262	2.9
Other heart diseases	601	3.0	348	2.6	100	1.1
Symptoms and ill-defined conditions	577	2.9	411	3.0	144	1.6
Anoxic and hypoxic conditions	559	2.8	590	4.4	d	-
<u>EUROPEANS</u>						
Ischaemic heart disease	441	19.8	459	22.0	318	23.2
Homicide and Injuries from other persons	298	13.4	121	5.8	2	0.1
Cerebrovascular disease	186	8.4	207	9.9	148 <sup>e</sup>	10.8
Malignant neoplasm of trachea, bronchitis & lung	85	3.8	90	4.3	41	3.0
Motor vehicle accidents	93	4.2	85	4.1	87	6.4
Malignant neoplasm of other & unspecified sites	109	4.9	114	5.5	70	5.1
Other pneumonia	82	3.7	78	3.7	19	1.4
Other heart diseases	80	3.6	66	3.2	18	1.3
Bronchitis, emphysema and asthma	73	3.3	68	3.3	32	2.3
Other transport accidents	67	3.0	5	0.2	8	0.6

N.B.: Notes to this Table 5.15 are on the following page

Notes to Table 5.15

- a - Bronchopneumonia
- b - Gastro-enteritis and colitis except diarrhoea of the new born
- c - Stated as 'ill-defined' diseases peculiar to early infancy and maturity unqualified
- d - Not indicated
- e - Under the heading 'Vascular lesions affecting central nervous system'

Source: SECRETARY FOR HEALTH REPORTS (1965, 1976 and 1979)



TABLE 5.16

NOTIFIABLE INFECTIOUS DISEASE CASES

DISEASE	AFRICANS			EUROPEANS		
	1979	1976	1974	1979	1976	1974
Trachoma	7107	5380	11184	nil	-	5
Anthrax	4002	29	-	nil	-	-
Malaria	3716	8335	87435	81	67	193
Pulmonary Tuberculosis	3064	3279	2938	12	22	15
Infective Hepatitis	873	484	284	173	112	99
Typhoid Fever	689	556	1527	12	14	11
Non-pulmonary Tuberculosis	400	515	361	4	9	5
Facillary Dysentery	389	422	446	196	215	117
Leprosy	237	334	455	nil	-	-
Tetanus	161	148	*	nil	-	-

\* - Tetanus was not among the top twelve notifiable diseases that year

TABLE 5.17

PRINCIPAL FACTORS OF REGISTERED INFANT MORTALITY (AFRICANS), 1979

DISEASE	%	DEATHS
Other pneumonia	18.2	850
Other causes of perinatal morbidity and mortality	15.9	746
Anoxic and hypoxic conditions not elsewhere classified	11.9	559
Enteritis and other diarrhoeal diseases	11.2	526
Measles	7.8	366
Tetanus	6.6	307
Birth injury and difficult labour	4.0	186
Other bacterial diseases	3.3	157
All other congenital anomalies	3.3	155
Meningitis	2.4	112

Source (for Tables 5.16 & 5.17): SECRETARY FOR HEALTH REPORT (SHR)  
1974, 1976 and 1979.

allocation of resources towards urban based, high technology, curative services.

The pattern of disease as shown in the tables is one that requires largely preventive and promotive measures. The need to expand MCH<sup>1</sup> services so as to cover the whole infant population with immunisation, could considerably reduce infant mortality from measles, tetanus and tuberculosis. Only two provinces in 1980 provided data to allow gross calculations on immunisation coverage which showed that only a fifth to a third of the target age-group in the rural areas were fully immunised against whooping cough, tetanus, diphtheria and poliomyelitis.<sup>2</sup> To obtain the desired high coverage, there is a need to improve the outreach services through allocating them more resources - transport, equipment, drugs, staff - and educating that population as to the benefits. Herein lies the importance of the need to recognise community structures which can effectively lead to the mobilisation of the mothers. In effect, it is not feasible to attempt to change the whole community's social outlook. Whereas the children are the worst affected by diarrhoeal diseases, for example, adults are also affected although perhaps not as severely.

Whereas medical interventions are of considerable

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1. MCH - Maternal and Child Health.

2. Health Sector Review, 1981 p.7.

assistance in reducing mortality, it was not these interventions which produced health improvements in Britain in the 19th century as shown by reductions in mortality and morbidity. It was social reforms - better housing, education, labour laws, improved water supply and sanitation and above all else, improved nutrition; which resulted in great reductions in mortality and overall health conditions before major drugs were widely available.<sup>1</sup>

The economic and social implications of diseases are recognised in the case of Zimbabwe when for example one considers the effects of malaria (it is endemic there) and schistosomiasis on productivity in the sugar estates of the lowveld. The high prevalence of these diseases reduces the activity levels of the workers and since the latter is debilitating it leads to loss of many workdays. In addition to that, these diseases affect pregnant women and the foetus leading to low birth weight babies. The children born may be mentally disadvantaged in terms of intellectual performance in school. This affects both the labour reproduction and family lives of the workers concerned through both stress and economic outlay in seeking care.

WHO<sup>2</sup> has estimated that 89 per cent of the rural

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1. McKeown, T. "The Role of Medicine", The Nuffield Provincial Hospitals Trust, London, 1976.
  2. WHO - World Health Organisation.



population in Africa lack reasonable access to safe water. The Secretary for Health in 1970<sup>1</sup> admitted that:

"the vast majority of the African population in Tribal Trust Areas obtain their water supplies from completely unprotected surface sources and shallow wells."

Because of the limited sewage disposal facilities - for both liquid and solid waste - this water is unsafe for drinking. But, since it is the only available water, the people drink it, and use it for cooking and washing. The result is the spread of typhoid, dysentery, cholera, as well as other intestinal infections which in addition to causing illness among the adults (thereby causing their productivity in the fields or at work to fall), are fatal to infants and under-nourished children. The one to five year age group is the most exposed. At the period of weaning, the withdrawal of the nourishing and immunologically rich mother's milk leaves the child exposed to both infections and inadequate food values. Cases of protein energy malnutrition abound in the rural areas unreported. Only when extreme cases of Kwashiorkor and Marasmus occur do parents seek medical care irrespective of the cost and distance. At least the removal of fee charges for those earning \$150 or less has meant that a major obstacle to care has been removed especially for the poor without any source of income.

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1. Report of the Secretary for Health 1970 (Zimbabwe)

The level of such cases as trachoma (7107 cases) and anthrax in 1979 among the African population only, is cause for concern. These diseases are the result of unhygienic conditions and they are highly infectious. This level of incidence says a lot about the level of health education, communication and contact between the African communities and the health workers. To be effectively tackled, it requires the participation of other sectors in conjunction with the health sector - eg Education, Agriculture, ..

(vii) CONCLUSION:

The population of Zimbabwe is characterised by wide inequalities in health status - which are the result of inequalities in access to wealth, income and opportunities. These exist between the whites and blacks, the urban and rural population and between the modern and the peasant sectors. Whereas those who enjoy good health (the whites and modern sector groups) have the best, those who suffer ill health (the blacks and peasant sector groups) suffer serious deprivation.

The pattern of diseases affecting the deprived population was shown to be mainly preventable communicable and nutritional diseases which are the result of under-development. The following factors were considered as contributory to the inequalities which exacerbate the differences in health conditions and affect the spread and severity of the noted diseases:

- (i) geographical and climatic conditions,
- (ii) demographic factors - population distribution and structure,
- (iii) the land question - its distribution by racial group and population density,
- (iv) income levels to assess numbers in poverty and the severity of the poverty,
- (v) social inequalities - inadequacy of housing, overcrowding and the provision of clean water and sanitation,
- (vi) educational inequalities - illiteracy rates and resources allocated to the different races and to urban and rural areas.

These factors are inter-sectoral and require a multi-disciplinary approach to tackle them.

The comparison of the health status of the population groups by disease category and incidence rates, by age group, the use of infant mortality rates and maternal mortality rates; all indicated big disparities between the races and between the urban and rural populations. Whereas preventable communicable and nutritional diseases are responsible for most African deaths, degenerative diseases top the list of causes of white mortality.

A planning approach and methodology which takes cognisance of the intersectoral nature of the problems and the need to employ a multidisciplinary strategy to



resolve them, is required. What came out in the discussion is that the problems of health lie at the root of the nation's struggle to develop. They reflect deep seated forms of differentiation between groups and within groups that constitute the nation. They require a complete overhaul of the system of: land ownership and utilisation, social organisation and provision (including welfare, education and housing) and political mobilisation - if equity in health is to be realised - this will be the subject of Parts III and IV.

Whereas the problems of availability and quantity of national resources at a level capable of sustaining a good level of health have not been discussed in this chapter, (it is tackled in Chapter VI) it is hoped that the task of identifying the gaps in health between the races and between the urban and rural areas has been accomplished. It was meant to show the seriousness of the problem of distribution which would adversely affect equity objectives whatever the level of national resources. The adverse effects are worse when the national cake is smaller. In our case it is bigger and it would be bigger still (by comparison with other UDCs of comparable size), if more people were allowed to participate in the income generating activities of the economy. This would be through making land available for intensive farming to capable families and through training in industrial skills for employment. Better wages accompanying these advances would mean increased consumption demand and the accompanying cumulative

effects across the productive sectors.

Distributive justice, which is political, economic and social in nature, is sought in the endeavours to promote equity in health. By enabling the poor to have something, you are according them a say which enables them to contribute, participate and criticise; which effectively erodes the power of the elite. By enabling them to own and have a say - they have the opportunity to improve their incomes and better their standard of living. They effectively become active members of the society. Equity objectives are seen here to better the standards of living of the poor and with it their health status. Even if this may mean sacrificing exceedingly high 'qualitative standards of care' for a privileged few, it means as a whole that the nation's health status is improved.

The deplorable health status of the majority of the African rural population can be understood through the systematic assessment of the broad factors that interact within a country; from the broad environmental issues to the specific disease conditions. In the next chapter, the problems of the health care sector (resources, allocation, manpower, materials, etc) are examined.

(i) THE CONTEXT

In the previous chapter, the health problems which affect the majority of the African population were examined. It was disclosed that they are the result of mainly economic and socio-political inequalities between the races and between the urban and rural areas. The Health Care Sector under normal conditions would concentrate on providing for the ill who are mainly from the underprivileged, low income earners in the urban areas, and the peasant population and agricultural workers in the rural areas. The high level of their health needs was viewed and seen to be the outcome of a deliberate government policy of underdeveloping the African population. To what extent does the Health Care Sector cater for the needy?

It is the intention in this Chapter to discuss the problems in the Health Care Sector and the level of the inequalities therein. This discussion will complete the picture of the gaping differences in health status and what efforts have been made to adequately cover the disadvantaged and to improve their accessibility to the service. The issues will be discussed under the following sections:

- (i) the fragmentation of the Health Care Sector,
- (ii) the preventive-curative dichotomy,
- (iii) the urban-rural dichotomy,
- (iv) the inequitable distribution of the health services.



- (v) racial and economic discrimination effects on access to care,
- (vi) the ineffectiveness of health care organisation.

It is acknowledged that the above subdivisions enable one to have a deeper insight into the particular problems in Zimbabwe, but they do not constitute the only possible classification of the problem areas. The major factors which interplay to determine the magnitude of the problems within the above are put forward as being Political and Organisational. This is consistent with the conclusion drawn in Chapter V that Zimbabwe's health problems are of a distributional nature and therefore heavily influenced by political trends. It is in line with these analyses that a political oriented problem resolution methodology for decision making is proposed in Part III.

THE FRAGMENTATION OF THE HEALTH CARE SECTOR

The Health Care Sector set up in Southern Rhodesia was meant to serve and reinforce the interests of capital and the white minority, through black exploitation and underprovision, as we discussed in Chapter IV. The mining concerns were required to provide for their workforce, the municipalities for those resident in their areas, but the other bodies that provide health care were under no obligation to do so. The Missions needed the care centres to demonstrate the superiority of their religion over the traditional Mwari cult; and also because the conditions of the natives, among whom they lived, placed a moral obligation on them to do something. Since they could not hope to get the government to care for the natives, they did it themselves and asked for some government support. The private sector grew because there was a demand for it (both modern and traditional) and secondly because the settler administration had used the right to practise privately in urban centres as an enticement to doctors to come and settle in Southern Rhodesia.

The government clearly did not object to this proliferation of service provision by all these different bodies. In fact it demanded their being set up in some cases (the mining centres, industrial concerns and municipalities), and encouraged their formation in others (missions and voluntary organisations). With the exception of minimum requirements, the government did

not enforce any control on the bodies nor did it prescribe an operative structural format (except in the case of traditional practitioners who were illegalised). Whereas the Municipalities in urban areas were under scrutiny, the rural areas which were out of sight of the administrators suffered from the implications of lack of clear guidance on facilities or services provision by these bodies - most of it perhaps unintentional. This attitude was consistent with the conception of health as a matter for the professionals and the individual who is ill; a servicing sector to facilitate the smooth functioning of the productive ones (eg commerce, industry, mining) and one in which political and economic controls and direction were infeasible.

The government service is funded from the national revenues where it has to compete for scarce resources, with other sectors. It has to demonstrate that the returns from the resource commitments justify the expenditure level. This requires demonstrating the effectiveness of the health care sector in contributing to the country's productive effort which means 'demystifying' medicine and showing that it is possible to apply economic and social measures of performance.<sup>1</sup> In itself, this requires that the Ministry of Health be informed on the size and mode of functioning of the

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1. Kleczkowski, B.M. "Technological Imperatives and Economic Efficiency in Health Care". A paper for discussion.



whole health care sector. This calls for a comprehensive and continuous review of the sector which would involve the preparation, costing and rationalising based on established criteria, of the whole sector's plans so as to align them with the government's policy objectives - in this case, to ensure that all sub-sectors work towards the attainment of 'equity in health' as part of the development strategy. The question which arises is whether the Health Care Sector is sufficiently integrated to enable the above.

The question of the health care sector financing is relevant as an indicator in the discussion of the problems of fragmentation of the services. Over the years, the proportion of the total amount of national resources devoted to the health sector, have been negligible because it was seen as a service sector which contributed nothing to the country's wealth. Total health care expenditure has been around 2 per cent of the gross national product until 1980/81 when it jumped to \$119 million which amounts to 4 per cent of GNP. This signified a change in the perceived role of health. This was a clear break with what Brian Abel-Smith (1967) gave as a rough upper limit of 2-3% of GNP expended on health by low income countries.<sup>1</sup> Whereas the 1976

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1. Abel-Smith, B. 1967. "An International Study of Health Expenditure and its Relevance for Health Planning". WHO, Public Health Papers No.32, 1967.

average annual expenditure per person was \$8,<sup>1</sup> for 1980/81 it was \$16 per person. This would work out at 7.3 per cent of the average annual income of a peasant farmer; 1.4 per cent of the average income of blacks in the formal sector and a mere 0.2% of the whites' average annual income (See Table Chapter V). If the service were provided and utilisation related to the proportion of income spent per person, this would relate expenditure on health to health needs. But as Professor Titmus rightly pinpointed, 'the higher income groups take up more than their fair share of the health resources.'<sup>2</sup> This will be examined in later sections. The fragmentation of the service itself makes it difficult if not impossible for the government to comprehensively plan for the whole sector, let alone for the attainment of allocative efficiency within it.

The health expenditure is divided between current expenditure, which in 1980/81 took \$111 million or 93.3 per cent of the total, and development costs which

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1. World Bank, 1980. "Health Policy". Appendix 3, p.99.
  2. Quoted in Hart, J.T. "The Inverse Care Law", The Lancet, February 27, 1971. Also Kadushin, C. "Social Class and the Experience of Ill-Health". Sociological Inquiry 34 (1964). Quoted in Ivan Illich (1976) p.238 (footnote). Members of the upper class as more competent in making use of publicly financed medical services, because of their greater sophistication and ability to use small payments for gaining leverage on large perquisites.

took the balance of \$8 million or 6.7%. The sector expenditure total excluded direct payments to private practitioners - both modern and traditional - self-care expenses, contributions from abroad and the cost of clean water and sanitation. The inclusion of these raises the amount of resources set aside for health and health related activities.

The Central Government is the main source of funding for health care. It was allocated \$84.6 million in 1980/81, which amounted to 6.2 per cent of total government expenditure. The central government funding provided 71 per cent of the total health care funds in 1980/81 as is shown in Table 6.1, the balance came from other sub-sectors. The funds from the government are used to finance the Ministry of Health services and the grant-aid other health care providers. The development costs are paid to the Ministry of Works which does the construction of facilities, and to the Ministry of Education for the Medical School. The private sector constitutes the second biggest source of finance - 24 per cent, through the Medical Aid Societies, a practice which has led to the government directly and indirectly (through tax exemptions for contributions, low charges for use of facilities and purchases of drugs exemption from VAT) financing nearly half the value of services of this sector which caters for the urban rich. If the value of the services to the Medical Aid beneficiaries is excluded,



TABLE 6:1

TOTAL EXPENDITURE ON HEALTH CARE 1980/81<sup>1</sup>  
( \$million )

Source of finance	Health care provider							Total	
	Central government	Municipalities	Councils in rural areas	Medical missions	Industrial enterprises	Private sub-sector	Voluntary organizations	\$million	percentage
Central government <sup>2</sup>	67,6	6,4	4,3	2,8	0,9 <sup>3</sup>	0,4 <sup>4</sup>	1,7 <sup>5</sup>	84,6	71
Municipalities		2,1						2,1	2
Medical missions				0,4				0,4	-
Industrial enterprises					3,6			3,6	3
Private	3,4 <sup>6</sup>					24,7 <sup>7</sup>		28,1	24
Voluntary organizations							7	7	-
Total	71,0 <sup>2</sup>	8,5	4,8	3,2	4,5	25,1	1,7	118,8	
Percentage	60	7	4	3	4	21	1		100

<sup>1</sup> This table excludes health-related activities by ministries and agencies other than those mentioned explicitly. It also excludes self-care, the work of traditional practitioners, and financial contributions from abroad (other than those of those through the medical missions). The figures quoted include both current and development expenditures.

<sup>2</sup> The main government provider of health care is the Ministry of Health. The figure of \$71,0 million includes \$5,0 million expenditure by the Ministry of Works on the building of health facilities and \$3,6 million spent by the Ministry of Education on the School of Medicine; the clinical staff of the latter give service on teaching wards of government hospitals. The remaining sum of \$62,4 million was the expenditure by the Ministry of Health on its own services. This figure plus the \$17,0 million payments the Ministry made to other health care providers (see top horizontal column) constitute a total expenditure of the Health Ministry. This was financed through the ministry's budget of \$77,4 million plus \$3,6 million fees retained by Parirenyatwa Hospital (see note 6).

<sup>3</sup> Payment for government patients at Wankia Colliery Hospital.

<sup>4</sup> Government payments for the care of the aged infirm.

<sup>5</sup> Expenditure on health personnel only.

<sup>6</sup> Fees of private patients in government hospitals. The figure is made up from about \$2 million paid by medical aid societies and \$1,4 million paid directly by patients. Revenue from either source to Parirenyatwa Hospital is retained by that institution, while all other fees go to the Treasury.

<sup>7</sup> Medical aid society expenditure, excluding some \$2 million fees to government hospitals (see note 6). The total medical aid society expenditure was therefore about \$16,7 million. Data on direct payments by patients to private practitioners and private health facilities are not available.

"public expenditure on health (by central government and municipalities) represented an average annual expenditure of \$11 per non-member".<sup>1</sup>

This figure is less than the calculated overall national average of \$116 per person. In effect the poor subsidise the rich to enjoy better care.

(a) THE MINISTRY OF HEALTH

In addition to providing most of the health care service, the Ministry transfers funds to municipalities, local councils, missions and the voluntary organisations. In 1980/81, its own budgetary expenditure was \$77.4 million which represented 65 per cent of the national expenditure on health care.<sup>2</sup> As is shown in Table 6.2 the 'medical services' sub-vote takes up the lion's share of the Ministry's funds (88%). It provides the curative network and most of the grants to the extra-ministry services. Preventive services are the next in size of allocation. They take up 8 per cent of the budget. Despite the nature of our disease pattern and the major causes of mortality being preventable, the allocation to this sub-vote has persistently remained below 10 per cent of the budget. In addition, they are run by the Provincial Medical Officer of Health (PMOH) who does not

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1. Health Sector Review, 1981, p.14.

2. Ibid p.15.

Table 6.2

MINISTRY OF HEALTH BUDGETARY EXPENDITURE<sup>1</sup>

Sub-vote	1979/80		1980/81		1981/82	
	£M.	%total	£M.	%total	£M.	%total (est.)
I Administration	2,1	4	2,7	4	3,9	4
II Medical Services <sup>2</sup>	46,6	87	68,1	88 <sup>2</sup>	95,8	88
III Preventive Services <sup>3</sup>	4,2	8	5,9	8 <sup>3</sup>	8,4	8
IV Research	0,5	1	0,6	1	0,8	1
Total	53,4	100	77,4 <sup>4</sup>	100 <sup>4</sup>	108,9	100 <sup>4</sup>

1. Fees retained by Parirenyatwa Hospital are additional to budgetary allocations; these fees amounted to some £2M in 1980/81 (see Table 2, note 2)
2. This sub-vote includes payments to other sub-sectors, including grants to municipalities, local councils, missions and other voluntary organisations. The expenditure on the government hospital services constituted 69 per cent of Ministry of Health total expenditure in 1980/81.
3. This sub-vote also includes grants to voluntary organisations. In 1980/81 rural preventive activities is closer to 7 per cent.
4. Column does not add up exactly to the total due to rounding numbers.



relate with the medical personnel at the General and District hospitals.

The biggest expenditure item under medical services is hospital services, which took up 69 per cent of the ministry's total expenditure in 1980/81. Four levels of care are provided by the government hospital system: central, general, district and rural hospitals. As is shown in Diagram 6(a) these constitute the national referral system. In Tables 6.3 and 6.4 the basic data on government hospitals and the resources in them in 1981 are shown. A picture of overprovision in the sophisticated urban based institutions emerges which confirms the distortion in favour of the rich and urban based minority population. Further distortion in care is shown by health workers distribution by sub-sector, Table 6.5.

The four central hospitals are situated in the main cities of Salisbury (Parirenyatwa and Harari) and Bulawayo (Central and Mysilo). Under the Medical Services Act, now repealed, Harari and Mysilo were the 'closed' hospitals catering for the black population while Parirenyatwa and Bulawayo Central were the 'open' hospitals catering for the whites. This led to a lot of duplication of expensive facilities. Whereas overcrowding and shortages characterised the 'closed' hospitals, sophisticated technology, high staff-patient ratio and best care, were the pride of the latter. The central hospitals have a total bed complement of about

DIAGRAM 6.a

MINISTRY OF HEALTH REFERRAL							
LEVEL OF CARE		INSTITUTIONS		EXPENDITURE			
		TYPE	No.	\$mln <sup>2</sup>		%	
MIN. OF HEALTH	CENTRAL HOSPITAL	QUARTENARY	4	33.0		44	
	GENERAL <sup>1</sup> HOSPITAL	TERTIARY	11	15.3		20	
	DISTRICT <sup>3</sup> HOSPITAL	SECONDARY	28	8.2		11	
Grant-in Aid	RURAL HOSPITAL	.....	46				
		PRIMARY		9.8		13	
LOCAL GOVERNMENT	CLINIC <sup>4</sup>	.....	450				
	Municipalities (incl. infectious-disease hospitals)			8.5		12	
	Town/Rural Councils } (incl. laboratory services and RMCH services)						
	TTL Councils						
Mission (part of secondary hospitals)							
Industrial							

N.B.: Notes on this Diagram 6.a are on the following page

Notes on Diagram 6.a:

- 1 - Includes special hospitals
- 2 - Current expenditure 1980/81 excluding grants to voluntary organisations, payments to other institutions for government patients and administrative costs
- 3 - Includes mission hospitals
- 4 - Total number of these is approximate and includes all clinics (mission, industrial, municipal, town and rural council).

Source: SECRETARY FOR HEALTH REPORTS AND SECTOR REVIEW, 1981



Table 6.4

## RESOURCES IN THE DIFFERENT CATEGORIES OF GOVERNMENT HOSPITALS, 1981

Hospital Category	Estimated Expenditure <sup>1</sup> per bed, £	Beds per doctor <sup>1</sup>	Beds per Nursing <sup>2</sup> Cadre	Nursing Cadres <sup>2</sup> per doctor <sup>1</sup>
Central	11000 <sup>3</sup>	13	2	7
General	5600	52	3	20
District	2300	150	6	26
Rural	700	- <sup>4</sup>	9	- <sup>4</sup>

1. Private doctors utilising government hospitals are excluded.
2. State registered nurses and medical assistants.
3. Includes an allowance for the services provided by the medical school.
4. There are no doctors in rural hospitals.

Table 6.5

MAIN CATEGORIES OF HEALTH WORKERS BY SUB-SECTORS, 1981<sup>1</sup>

Sub-sector	Doctors	Nursing Cadres		Preventive Cadres	
		SRNs	Medical Assistants	Health Inspectors	Health Assistants
Government <sup>2</sup>	303 <sup>3</sup>	1740	1539	21	269
Local Councils	0	45	325	0	0
Municipalities	14	187	477	54	74
Missions	29	85	281	0	0
Industrial	37	76	247	?	?
Private	279	98	18	0	0
Total <sup>2</sup>	662	2231	2887	75	343

1. Based on a survey carried out by the Ministry of Health. Employees of voluntary organisations are excluded, as are nursing cadres in private practice or working for private practitioners.
2. The main government health care provider is the Ministry of Health. The number of doctors includes 39 employed by the medical school, whose clinical staff give service on teaching wards of government hospitals.
3. The totals are lower than the numbers of cadres registered with the Council of Medical and Allied Professions in November 1980, since not all registered health workers are practising.

Table 6.6

STARTING SALARIES OF 'EMPLOYEE' AND PROFESSIONAL GRADES  
IN GOVERNMENT SERVICE, 1981  
(£)

'Employee'	Starting Annual Salary	Professional	Starting Annual Salary	Ratio
Medical Assistant	2076	State regd. Nurse	4872	1:2.3
Health Assistant	2076	Health Inspector	6504	1:3.1
Laboratory Assistant	2028	Laboratory Technologist	6252	1:3.1

3,000. They are supposed to act as the national referral centres but in reality, they mainly cater for the population of the two cities. This has meant that their resources are diverted to basic inpatient care. They provide specialist services and have teaching facilities for the use of the School of Medicine based in Salisbury. In all, they consume one third of the health budget, ie 13.6% of the total population consumes thirty-three and a third per cent of the total health budget. The two main cities of Salisbury and Bulawayo for which the Central hospitals mainly cater, have 13.6 per cent of the total population.

There are eleven general hospitals based in the smaller urban centres. These have a total bed complement of 2038 beds and vary in size from 64 beds (Enkeldoorn) to 280 beds (Gatooma). Separate facilities existed in these for public and private patients. The repeal of the Medical Services Act is the first step taken towards integrating their services. These facilities should have more than one doctor and should cope with most medical and surgical problems referred from the district and rural hospitals under their supervision. Their location in the smaller urban centres has meant that most specialist vacancies remain unfilled because this staff category is attracted to the better equipped central hospitals or to the more lucrative private practice. The ending of the practice of allowing private patients into these public facilities may result in increased shortages of doctors.



District hospitals, of which there are 28 scattered throughout the country, mostly cater for the rural black population; although commercial farmers have access to the small private wards and to the district medical officer - a practice carried over from the early settlement days. They have a total of 2400 beds to act as the referral for a rural population of 6.1 million people! As a result, they are overcrowded and are in a state of disrepair. Each one should be manned by a doctor but in July 1981 there were only 16 doctors in all district hospitals.<sup>1</sup> No defined referral procedures to general hospitals exist nor are there any supervision arrangements.

The rural hospitals are the lowest provided government facility in the rural areas. They were meant to provide an outreach service and so have poor facilities, simple equipment, no operating theatres, X-ray machines and often no electricity. They do not provide food for the inpatients and are headed by Principal Medical Assistants. There are 46 of these and a total of 2029 beds. Only a limited range of health problems can be treated and little supervision by doctors is given mainly because they are located in the remote parts of the country. One-fifth of total rural deliveries takes place in hospital, the majority of which are at these units. These are handled by the Medical Assistants who man these

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1. Health Sector Review, 1981, p.20.

services. A look at the national maternity facilities provision shows that the private sector is much better off with 200 government hospital beds and a very low occupancy rate. The whole of the public sector at the central and general hospital level, is left to make do with 400 maternity beds overcrowded and with high occupancy rates. Cases of mothers giving birth on floor beds are common. It is therefore no wonder that only complicated cases are forced to make the long journey to hospital where prior to 1st September 1980 \$10 was payable for a maternity bed.

A number of centrally directed activities and programmes exist which include dental care and laboratory services. The former are mostly provided to state employees like policemen, prison officers, doctors and nursing students. White school children are covered by a dental inspection programme throughout the country which does not apply to African schools. Tooth extraction by trained medical assistants is the only service available to the black rural population. There are four government dental centres in Salisbury, Bulawayo, Gwelo and Umtali. These are run by the Chief Government Dental Officer. Ninety-five per cent of all practising dentists are in the private sector. The research services carried out by the Blair Research Laboratory, take up one per cent of the budget. It has concentrated on Malaria and bilharzia among other activities and has made significant breakthroughs in technological innovation for the supply of clean water and for good sanitation through the Blair



hand-pump and the Blair-privy. These can be afforded by the rural population and are easy to install and operate. If the government could promote their wider usage, these could significantly reduce our mortality and morbidity levels.

The fragmentation of the ministry's mechanisms, whereby the laboratory services make these gadgets for use by other staff, under another sub-vote-preventive services without any working co-ordinative mechanisms between them, means that no full advantage is taken of these advances. In addition, the PMOH staff only operate after the local authorities have decided to set up the clinics or to hire the Health Assistant. There is no mechanism whereby the staff can get the local authorities to initiate these activities. Even if the population were enthusiastic on installing the facilities, there isn't enough PMOH staff to supervise the installations.

(b)

#### THE GOVERNMENT HEALTH SERVICES

These were divided into district councils in the communal areas, the rural councils in commercial farming areas and the town councils and municipalities. The municipalities operate health services under the administration of local government in the twelve larger towns.

Municipalities operate clinics, polyclinics, maternity services and preventive services depending on the size



of the town or city and the resources available to it. Prior to the introduction of the free service under which the government funds all services 100 per cent, municipal services charged fees and had the remainder of the funds from rates and beer profits; with the ministry funding only 27 per cent of the costs in 1979/80. There was a clear distinction between African and European provision and since municipalities had no statutory obligation to provide health services or adhere to health priorities set by the ministry, wide variations in levels of provision exist. The only way the ministry can exercise some control is when it assesses the grant-in-aid. As shown in Table 6.1 these do consume a sizeable share of the national expenditure in health (7%) and require to be properly integrated in the national service and criteria for provision and control should be set. Whereas rich municipalities like Salisbury have been able to set up a network of polyclinics, the poor ones have neglected their service levels. It is the low income earners who invariably suffer in situations of inadequate provision because they have no means of recourse to the private sector, in the face of shortages in the public sector.

The district councils in the communal areas (TTL councils) constituted the local authority therein through which the Ministry of Health grant-aided the clinics. Those areas where no council existed had no services and often these were remote and poor areas. Before September 1980, the clinics were funded one-third

each from: fees, council revenue (from local population taxation and grant) and the ministry of health.

Whereas the PMOH supervised the staff the council had administrative responsibility, which was cause for a lot of inefficiencies and confusion. The clinics were staffed by medical assistants and since the sizes of the units varied from council to council, so too did the number of staff. They carry out exclusively curative work and with the backing of the mobile services from the PMOH, carry out well baby clinics (these amount to antenatal and postnatal care).

These units became the targets of the liberation forces for the reasons deducible from the above. Councils were considered to have been set up in those areas headed by submissive chiefs to the Smith Regime. The fact that they were partially funded by the Ministry meant that they were an extension of the government machinery. Since the Provincial Authority and the District Commissioner headed council administration, this was seen as complicity with the white system. The old hatred of the role of the D.C. as an office of oppression, made clinics targets. Most of them were therefore destroyed during the struggle. The regime too destroyed some when it moved people into the 'protected villages' wherein it set up other clinics to care for the population headed into them.

It followed from the above that those areas which were near urban centres, roads or railway lines, which were



fairly developed and still overseen by the government, got better supervision and support. Better still, they remained open providing some care. These remote areas, unsupported or forced to close, remained without any health infrastructure, were in dire need and were slow in re-opening after independence. There was no obligation to provide care anyway under the old law. With the introduction of the free services and the re-opening of centres and construction of new ones, has come the call for more defined minimum standards of care, better staffing levels and more structured supervision for the rural clinics since attendances have doubled - a sign of increased utilisation.

The situation in the commercial farming areas is even more serious. Since these are not under any legal obligation to provide health facilities for their employees, who, as we discussed in Chapter IV, live in poverty and are malnourished, the services they provide are haphazard and grossly inadequate. Only 76 rural and town council clinics exist to serve over one million people in these communities spread throughout the country. The PMOH provide supervision which is very poor because of the inadequacy of the infrastructure. With the government now providing 100 per cent funding it is essential to organise these services and link them with the national network. They have to become part of the District Services.

The assumption by the government of the responsibility to



fund health services 100 per cent has increased both its current and development expenditure from \$0.6 million to \$2.7 million and from \$0.1 million to \$1.9 million respectively - between 1980 and 1981. One of the problems which arose was whether the ministry's administration was properly geared to disburse the funds as required. This is assessed in another chapter because it raises the issue of whether the new philosophy sunk well with the old executors or implementors in the ministry's administrative structure.

Whereas the urban local government authority responded from fear of contagion and actually provided the most facilities for the African population, the farmers were not equally responsible. This is not to say that they were not equally afraid of contagion, but merely to show that most farms were manned by managers - the poor whites from South Africa, and locationally, the African labour compounds were miles from the Manager's house. In addition, the District Health Officer was paid for visiting them.

(c)

#### MEDICAL MISSIONS

The missions that provide health services fall into two categories: the grant-aided missions, of which there were 53 in 1979, and the non-grant aided of which there were 26 in the same year. Their services vary from the rudimentary clinics to sophisticated hospitals. The history of these services was discussed in

Chapter IV, only those aspects with a bearing on resources they consume and how they relate to the Ministry and among themselves are examined here. Their training of medical assistants, the key health personnel in Zimbabwe's rural areas, has enabled government institutions (which have only two training institutions for medical assistants) to recruit these in large numbers (see Table 6.3).<sup>1</sup> These offer a high return on costs incurred, which amounts to savings of scarce health resources. However it is often the insistence by the religious missions on training only female students which limits their potential contribution.

The medical missions practice not governed or regulated by any law primarily because the colonial governments were content with giving them a free hand in the TTLs thereby releasing government funds for use in the preferred white community and the urban and modern sectors. The only time the ministry was involved in the missions' work was when it had to grade them for the grant-in-aid. This covered only the grant-aided missions to an average of one-third of the cost; fees and donations covered the bigger two-thirds. Medical missions were therefore grossly under-financed despite

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1. Missions ran in 1981 seven training schools for Medical Assistants, and plans to re-open a further six schools closed during the war are underway. By comparison the government ran only two training schools in Que-Que and Morandellas before the introduction of the military medics training programme in Gwelo and Umtali in 1981.



the fact that they are often the only service available for thousands of rural African population. In 1980/81 despite that as a subsector missions provide 5000 beds, they spent \$3.2 million (3 per cent) of national health expenditure! As is shown in Table 6.3 the central and general hospitals have 5038 beds in all, but they consumed \$48.3 million (64 per cent of health services expenditure) in 1980/81.<sup>1</sup> The services the two groups of facilities provide for the rural and urban populations respectively, are roughly the same. The differences in resources spent per bed show the extent of the inequity of the quality of care for the population groups.

The location of the medical missions in the TTLs and the prime purpose of their construction - to serve the inadequately catered for African population - made them targets of the regime forces during the liberation struggle. Most of them were forced to close. Whereas in 1973 there were 44 doctors in the missions, by 1979 only 12 remained.<sup>2</sup> They have however resumed their work with speed since independence, so that by early 1981, 29 doctors were deployed in re-opened hospitals. With the introduction of the partially free health service should come increased government financing and involvement in mission services provision. This would hopefully be accompanied by improved quality of care.

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1. Ministry of Health sources.

2. Secretary for Health Reports, 1973 and 1979.



Whereas the training of medical assistants, a big contribution to the nation's health effort, is more or less standardised through a single examination board for the trainees, the denominational variations among them lead to differences in organisation and approach. One notices that in addition to differences in the size and level of facilities there are differences between the denominations and between them and government services organisation. This adds to the confusion of the rural populations as to the aims of health provision. Through the Zimbabwe Association of Church Related Hospitals (ZACH), they have managed to form a body on which they are all represented. It is the hope that more comprehensive coordination of their facilities and government services through the district health services structure, will promote a more rational and equitable service. Most important, would be their involvement in preventive health an area they have completely stayed away from.

A number of voluntary organisations have also been involved in health-related activities. These ranged from care for the disabled (Jairos Jiri), the blind, the aged and leprosy or tuberculosis patients. These were mostly concerned with chronic conditions, an area neglected by the Ministry. Each of the organisations that provided some form of care had its own hierarchy and structure with no effective co-ordination at all. The ministry contributed by paying half the salaries of the personnel, a proportion which has increased to

100 per cent since 1981. The extent of the fragmentation in these organisations was such that parallel facilities were provided for blacks and whites with the accompanying costs of duplication.

The largest ministry of health subsidy to a voluntary organisation is to the Family Planning Association which in 1980/81 received \$1.3 million. The Rhodesian government had from 1971 insisted on representation and control of the FPA Executive Board to ensure the slowing of 'the accelerated rate of increase of the African population'.<sup>1</sup> Clearly the tone of the country's politics was carried in such organisations thereby undermining their credibility among the African population who need child-spacing advice. It was on these grounds that the Ministry took over total control and administration of the Association in 1981.<sup>2</sup> A need to integrate its activities with the mainstream of maternal and child care programmes exists.

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1. The Secretary for Health, in the Secretary for Health Report, 1970.
  2. The majority rule government had to take this move both for the demonstration effect (to show that it was in total control of all activities) and because the Association was headed by reactionary white elements who opposed Ministry views.

(d)

INDUSTRIAL MEDICAL SERVICES

This sub-sector accounted for 4 per cent of the national health care expenditure (\$4.5 million) in 1980/81. Its checkered history was discussed extensively in Chapter IV where it was shown that the need to reduce absenteeism and keep mineral output high compelled the mineowners to provide some rudimentary services. The government to enforce or even oversee the mine health services, was contributory to the low level of care and the slow growth of the service. Under the 1977 Mining (Health and Sanitation) Regulations, the mines which employ over 300 workers are required to provide medical facilities. So in 1981 there were eight mine hospitals, three hospitals provided by other industrial and farming concerns, plus 19 industrial clinics. These employed 37 doctors, 76 SRNs and 247 medical assistants.

A number of aspects require to be scrutinised closely. These are concerned with the quality of care and the standards of care provided. Since the Act does not specify, the Ministry must work towards increased supervision of these to ensure they are in line with its own provision levels. With regard to those workers in jobs that expose them to hazardous substances - asbestos mining, coal mining and farm workers who use pesticides, the ministry must enforce protective measures. Present practices of merely registering and licensing premises are very deficient. This clearly



calls for joint working with other ministries like Labour and Social Services. Since the mines are responsible for the housing of their labour force, should similar conditions to the town councils be applied? The neglect of African workers housing and other social provisions was responsible for the high death rates in the mines prior to World War II, so some form of supervision comparable to similar population centres ought to be enforced by the Ministry. Special emphasis should be put on preventive and promotive care.

(e)

PRIVATE SUB-SECTOR

This sub-sector is made up of private practitioners - traditional and modern - private hospitals and private facilities in government hospitals.

The desperate need to attract doctors to the colony so that they could act as guarantors of good health to prospective immigrants, led to the granting of over-generous concessions to them from the early settler days. District Medical Officers were allowed to operate a private practice in the urban centres, over and above their normal duties. Inevitably this made them one of the highest income earning occupations. The private sector now has approximately 300 doctors, a number constituting about two-fifths of the registered doctors in practice in the country, and equal to the total number of doctors employed in the ministry of health. Under the Nursing Home Registration Act, the ministry has little control over the quality of care or the number of beds in the private hospitals registered. By 1981, there were around 300 acute care beds in the private hospitals throughout the country, including in smaller nursing homes. In government hospitals, there were 1500 private beds throughout the country. The main cities, which have 95 per cent of the specialists also have the majority of the private beds. The repeal of the Medical Services Act, has resulted in a big reduction of the number of private beds. The white population which constitutes the main user of this

service, has noticed this with apprehension and continued to seek ways of retaining the privileges therein without breaking the law.

The private sector consumes 24 per cent of the total health resources. Medical Aid Societies make most of the payment on behalf of their beneficiaries to the private sector. These beneficiaries have been until recently (1981) white, and remain the economically well-off. The Societies get their funds from contributions on a dollar for dollar basis by employees and employers, including the public service for the staff grades. This gave a lot of advantages to the employees, who had the whole contribution allowable from income tax. The luxurious benefit of private medicine obtained was further exempt from sales tax! The employers in turn had their contribution allowable from the taxable amount. The societies obtained a discount for the use of government hospitals and 10 per cent on bills. The private patients are offered hospital beds (preferentially) at a fee around one-third of their cost! Without going into any detailed calculations, it is clear that the government funds two-thirds of luxurious care for the rich. Since everybody contributes to the treasury funds through direct and indirect tax, a situation whereby the rest of the impoverished majority African population (especially the rural poor not benefitting from urban cover) subsidises the rich to receive first class care exists in Zimbabwe.



The Ministry's lack of say within the private sector despite its being the main contributor and provider of facilities, amounts to abdication of authority over sizeable health care resources which should be available to the nation. This becomes more vivid if one considers the fact that the Ministry of Health finances the training of health staff whom the private sector subsequently absorbs.

It is now becoming noticeable that the class nature of the care provided by the modern private practice, accounts for its stubborn resistance to the government efforts to integrate the health care sector and to rationalise health resources. In this, it is backed by the white national bourgeoisie and racialist white workers, who see the continuance of private health care as a stand against 'socialisation' of medicine.<sup>1</sup> The applications throughout 1981 for permission to construct private hospitals, sponsored by private companies in all the towns and cities; can be viewed from this perspective - following upon the desegregation of public medical care through the repeal of the Medical Services Act.

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1. The National Association of Medical Aid Societies (NAMAS) actually instituted a research study to propose ways of avoiding 'socialisation' of medicine in the face of the inevitability of African majority rule. This was the exact reaction of the Medical Associations in Britain in 1947 when Aneurin Bevan was preparing to introduce the NHS.

A number of deductions can be made from the discussion on the fragmentation of health care provision which have to be addressed to, if 'equity in health' is to be attained. It can be concluded from the discussion above and other aspects we shall consider later, that fragmentation was a calculated political move to enable the ruling class to obtain excellent care at little cost to themselves. It was a move which ensured that the bourgeoisie did not have to pump a lot of resources into African care although they stood to benefit most from a healthy African labour force. The service fragmentation enabled the rich to obtain subsidised first class care to the tune of two-thirds of the cost, from public funds.

The isolation of the rural areas and the consequent neglect in terms of budgetary allocation, added to the problems which the missions and local authorities had to grapple with. In the government's view the existence of those bodies justified its non-involvement to the level it should have been, in these rural areas. Since the bodies were accountable in the main to some other authority other than the Ministry, it meant that the Ministry could absolve itself of the responsibility for the rational use of the resources by these bodies. The lack of any co-ordinative mechanism therefore ensured that the absurdity of the poor subsidising the rich in health care provision, remained unexposed. Since the government planned its services according to the 'felt needs' it meant that those people living where no



governmental service existed were ruled out from any calculations of 'felt needs'. Inevitably, these are the people in greatest need in the poor and remote rural areas, where rudimentary missionary provision exists, unbacked and unsupported by the ministry infrastructure.

Brian Abel-Smith (1967) makes the point that multiple sources of health financing increase expenditure on health services through increased administration costs and inflated prices of certain health products without necessarily providing a better service. This is true in the case of Zimbabwe where it does not even lead to the covering of those who need the care. Fragmentation therefore works to the advantage of international capital and the bourgeoisie who have an interest in setting the bodies against each other, creating artificial shortages to force up the price or supplying only the private sector to boost the practitioners' earnings and at the same time lower the credibility of the public sector.

One cannot fail to observe that class issues, politics of privilege and the profit motive interact to pressure for the maintenance of fragmentation in the health care sector. The changing mode in portraying issues (ie the variations in health problems emphasis) is in keeping with changing external realities in the broad political arena. Of relevance is the vigorous pursuit of private hospitals expansion by the private industries under the



banner of responding to the government's call to ensure that every Zimbabwean has access to health. Their requests to build private hospitals in every town have been turned down by the government after analyses showed clearly how this in effect perpetuated two levels of care which went against the letter and spirit of 'equity in health'.

Although the question of fragmentation is high among the problem areas in the health sector, it is not by any means the only one. It however remains one that cuts across the whole sector hence the emphasis on integration in the proposed approach. The following sections examine in brief, the other factors contributing to the health care sector problems and inequalities.

(iii)

PREVENTIVE-CURATIVE SERVICES DICHOTOMY

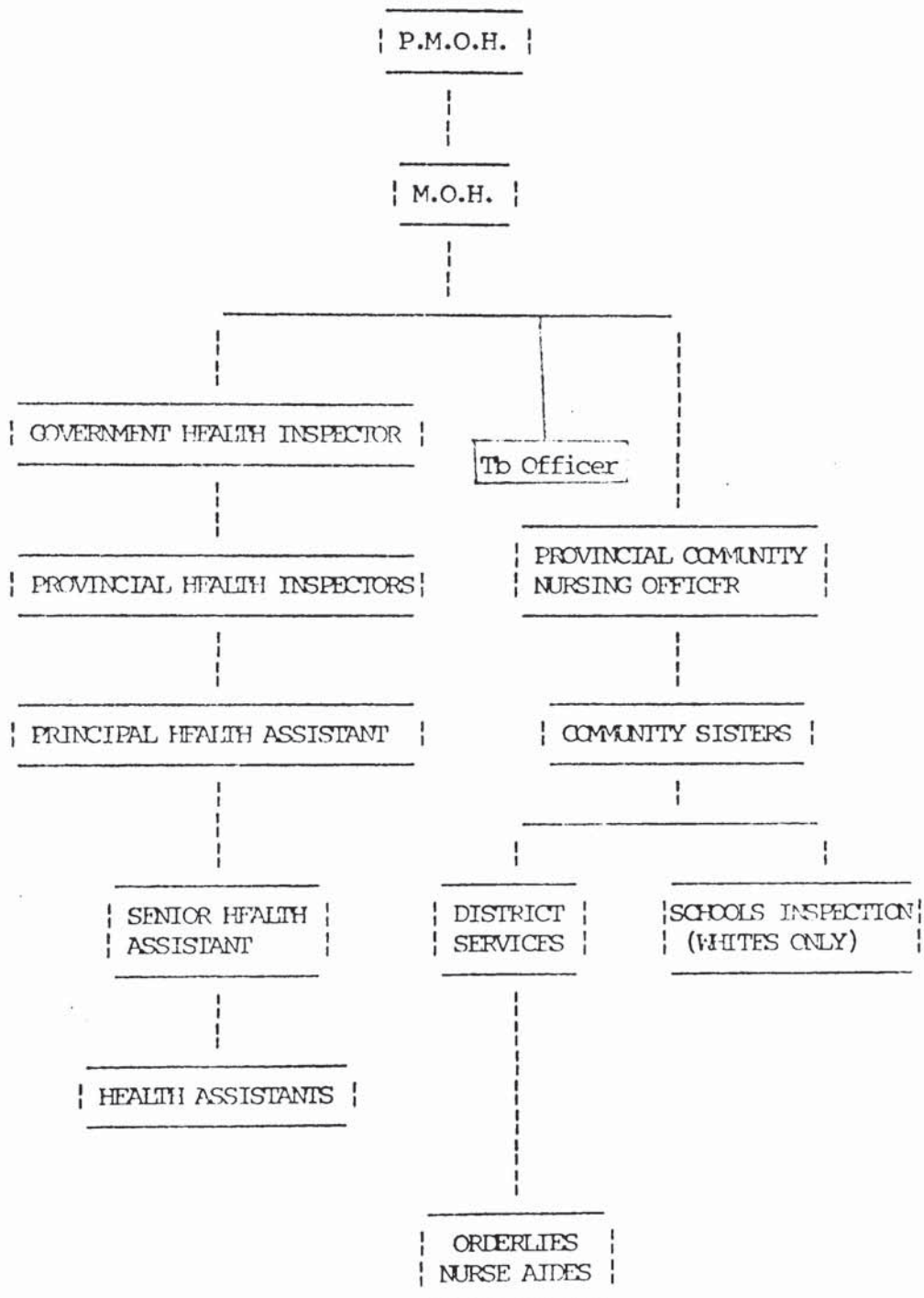
Dr H S M Ushewokunze, et al (1980) in "Behind and Towards a Health Model for Zimbabwe", observes that 90 per cent of the diseases in Zimbabwe are preventable, and yet the health budget allocation to preventive services has persistently stood at 8 per cent (Table 6.2). Admittedly the funds allowed have increased significantly, but what has prevented the allocation to this sub-vote to increase with the Ministry policy change of emphasis to Primary Health Care? The answer lies in that the service is highly medicalised and skewed in favour of curative high technology care which serves the modern sector. In addition, the vertical and non-integrative nature of the sub-sector militates against the holistic approach that would enhance the sub-sector's contribution to the health effort.

There are five health provinces each one headed by a Provincial Medical Officer of Health (PMOH). The hierarchical structure of the PMOH's office is as shown in Diagram 6.6.

There has never been any concerted effort to make this public health wing of the Ministry as active as it should be. Despite the fact that it is primarily responsible for environmental health, its functions have been more or less 'putting out of bush fires'. In a discussion with the Provincial Health Inspector

DIAGRAM 6.b

PROVINCIAL MEDICAL OFFICER OF HEALTH'S ORGANISATIONAL STRUCTURE





for the Midlands Province (June 1980), I was informed that, despite the high prevalence of malaria and the Province, some whole districts had not been sprayed against malaria for at least five whole years! The one team that existed, was under-equipped, poorly trained and did not have an efficient supportive infrastructure. Out of the eight districts in the province, it could only manage to spray residual insecticides in one a year. This was because of a variety of reasons ranging from the intensity of the war, inability of the District Councils to maintain roads in the TTLs, to poor staffing levels. The staffing level of the sub-sector, characterised by grave differentiation, is poor to a level where, despite appropriate technological breakthroughs like the Blair Privy and hand pump; they have been under-utilised.

Staffing problems originate from the racially based categorisation in training and subsequently in salaries classification. Whereas the Health Inspectors qualification is professional and internationally recognised, the Health Assistant is an employee despite the fact that the length of training for both is three years and the entry requirements 'O' levels. The one was for whites, with emphasis on urban oriented meat inspection - hence most are employed by the Municipalities;<sup>1</sup> whereas the other, more relevant to

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1. These employed 75 health inspectors in 1981 the majority of whom were meat inspectors. In 1979 only 12 health inspectors completed their training.

national health as a whole, emphasised environmental health. The wage differentials between them, as between similar differentiations in nursing is shown in Table 6.6. It is important to note that the inadequacy of the numbers trained and posted;<sup>1</sup> of the health assistants, contributes to the low level of awareness of the public health measures among the rural population. In addition, they assist the Community Nurses during the well-baby clinics mobile services - with the weighing and immunisation of babies, and do tuberculosis case finding, tracing and monitoring. Although community nurses do work with HAS there are a lot of co-ordinative mechanisms which need to be developed. The limiting of schools inspection by community nurses to white and urban schools does not, as in other health services provision spheres, seem to relate provision to need. The HAS have replied by carrying out some rudimentary African rural schools inspection for trachoma and other easily identifiable diseases, accompanied by the distribution of eye ointment to the teachers to apply to affected children's eyes. This practice was well advanced by June 1980 in Charter district. The mobile services provided by the community sisters from the PMOH staff have a 'sporadic character', rather than a 'continuous activity' outlook. This creates the wrong impression that health

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1 The total number of registered Health Assistants (1979) was 358. These have too big areas to cover on bicycles to be effective.



matters must be attended to once a month, whereas they should be everyday concern for every individual, family and community. Towards this end, the number of Health Assistants (now standing at 358) has to be increased to improve their coverage and their training should be geared towards joint working with the Medical Assistants on a daily basis at the frontline centres. This of necessity calls for the retraining of both categories of existing workers.

The Western inspired curative services delivery system (see Diagram 6.a) has been almost universally adopted at the national level despite the observation by Katz et al (1979)<sup>1</sup> that:

"... as designed, it is inefficient, dependent on expensively trained personnel, often grossly over taxed by the level of expectations and demands upon it; and generally of limited relevance to the conditions and goals of developing countries."

With the cost of training a doctor at \$5000 a year for five years and a State Registered Nurse (SRN) at \$3426 per year for three years, (these are rough estimates established by the Training-Co-ordination Unit in the Ministry of Health during the Health Sector Review, 1981)

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1. Katz, Sydney, Good, Hunter and Katz, Selig. 1979 "The Interface of Dual Systems of Health Care in the Developing World: Towards Health Policy Initiatives in Africa". Social Science and Medicine, Vol.130, p.142.



these constitute the key personnel in the Central and General Hospitals as shown in Table 6.8 and 6.9; it is doubtful whether the returns to the nation as a whole justify the resources committed. This becomes more questionable if one examines the sections of the population who use the tertiary and quaternary levels of the service which take on 71 per cent of the SRNs and 79 per cent<sup>1</sup> of the doctors in the publicly funded services. If one adds the fact that the Ministry employs only two-fifths of the doctors, half of the Specialists and half the SRNs trained with public funds, with the rest joining the lucrative private sector or emigrating; the full burden on the national resources is shown.

The curative services shown some of the widest forms of differentiation in care, staffing patterns and between staff in the whole health care sector. More relevant for our study is the inappropriateness of the philosophy of western technology medicine which emphasises individualistic methods of treatment. It seeks remedies within the individual internal system, rather than as is consistent with the African culture, within the wider system, the external environment. It thereby places responsibility for the restoration to normality upon the doctor and the individual concerned, as if these could function independently of the wider

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1. Health Sector Review, 1981.

TABLE 6.8

OCCUPANCY RATES IN 'OPEN' AND 'CLOSED' WARDS, 1979

HOSPITAL CATEGORY	'OPEN' GENERAL WARDS		'CLOSED' GENERAL WARDS	
	Beds	% Occupancy	Beds	% Occupancy
CENTRAL	850	70	1724	92
GENERAL	357	34	1401	102

Source: HEALTH SECTOR REVIEW (Ministry of Health, 1981)

political, and socio-cultural system. Its emphasis on the efficacy of medicine and the physician, has led to what Ivan Illich calls 'clinical and cultural and symbolic' iatrogenesis.<sup>1</sup>

"By claiming predictable outcomes without considering the human performance of the healing person and the integration in his own social group, the modern physician has assumed the traditional posture of the quack."<sup>2</sup>

Since in reality the expansion of medical services is an admission of the failure of the health system, where is the wisdom in glorifying - curative services? In view of the nature of the predominant diseases, which are infectious, communicable and nutritional; providing extensive curative facilities to the sick, who once recovered are returned to the old infected environment only to contract the disease again and come back into hospital; is a waste. The only group that benefits are those suffering from other than the major diseases affecting the majority of the population. These are the privileged, economically well-off who constitute an

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1. Illich, Ivan. "Limits to Medicine: Medical Nemesis - The Expropriation of Health". 1976. He states that iatrogenesis is clinical when: pain, sickness and death result from medical care; it is cultural and symbolic when medically sponsored behaviour and delusions restrict the vital autonomy of people by undermining their competence in growing-up, caring for each other and aging, or when medical intervention cripples personal responses to pain, disability, impairment, anguish and death. (p.270).
  2. Ibid. p.253.



urban minority.

The differences within the curative services are also very marked. The former 'open' hospitals were well-equipped with expensive high technology facilities, had the services of the specialists, high doctor-nurse, nurse-patient, medical-paramedical ratios; and low bed occupancy rates. They as a result incur high expenditure per patient per day (see Table 6.8). By comparison the 'closed' hospitals had high occupancy rates, low doctor-nurse, nurse-patient and other professionals ratios. The quality of the service provided, and the quantity as shown by high bed-population ratio; is low, the staff is overworked and the facilities and supplies strained. With increased risks of cross-infection and inadequate care, it may be more dangerous to seek hospital treatment than not to be admitted at all. This further raises the problems of drugs and equipment supplies. Experiences in advanced countries have highlighted the dangers of over prescription by doctors, use of drugs whose side effects are not fully understood and costly drugs prescriptions the result of advertising and Transnationals selling activities.

An analysis of hospitals expenditures showed that in 1980/81 some hospitals bought directly from drug companies. There are many dangers in this practice ranging from costly buying to poor quality control. In addition there is the wider problem in Zimbabwe and all

other under-developed countries, which is that drugs are imported. This means that we have to compete with other sectors for foreign currency allocation. The need to rationalise and prioritise the drugs we require is imperative such that we cannot leave it to private enterprise to import the drugs they want. The hitherto role of the Central Stores has been one of 'breaking the bulk' through a system of tenders to firms. With the change in emphasis towards the rural areas, the need to develop an efficient delivery system of essential drugs calls for a re-vamping of the Stores functions and organisation.

Some of the criticism labelled against the Ministry of Health in its provision of curative services stems from the below-cost provision of facilities for private practice. This is seen as a manifestation of class interests protection and cohesion among the elite. Since the medical profession has always exercised a lot of political power, they used it to provide these advantages to themselves and in addition evolved a system whereby the privileged classes in the society who could have objected, were to receive first class care at a minimal charge. In fact, the practice of government responsibility patients in Zimbabwe- who are entitled to free access to a wide range of health care services is linked to this selective and racial practice.<sup>1</sup> In addition, because government provision

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1. See Footnote 1 on following page.



of curative services only got to the rural hospital level, the mass of the rural population was left - until recently, inadequately funded. The worst hit are the remote areas with nil facilities and no district councils.

The disparities between preventive and curative services reflect the differences in the health sector which are:

"symptomatic of the distribution of economic<sup>2</sup> and political power within society."

Although Navarro admits that professionals have a dominant influence, they do not have actual control of the structure of the health services. Actual control is through, 'the ownership of the means of production, reproduction and legitimation held by the capitalist elite'. In effect this view reaffirms the proposition made throughout this study that the issues and problems of health and in the health care sector hinge on the

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1. A specific study of Government responsibility patients was instigated by the Minister of Health in 1981. It showed that \$1.02 million was spent on these patients which consist of: (a) those who are working or have worked for the government - Armed Forces, War Pensions 1939-45 war, Police, Prison Officers, medical professionals and employees and (b) Others - prisoners, old age pensioners, South African old age pensioners, Pioneers, Religious Ministers, etc.
  2. Vincente Navarro: "Social Policy Issues: An Explanation of Composition, Nature and Functions of the Present Health Sector of the US." 1974. Quoted in Ivan Illich: "Limits to Medicine". 1976, p.251.



economic and social benefits determined by the exercise of political power. To bring about the change in emphasis required by Primary Health Care calls for the shifting of the power centre - economic and social - through political processes, from the capitalist elite to the majority worker and peasant population. Whether the existing Public Services Commission can effectively do that remains to be seen. Our later analyses tend to suggest that it may be limited by the operational structures within which it works.

The preventive-curative dichotomy is one of three dichotomies of which the urban-rural and black-white (poor-rich) are the others. These are examined in turn below.

(iv)  
URBAN-RURAL DICHOTOMY

Why consider the urban-rural dichotomy? It is important for the planner to establish a population base for objective planning and evaluation. White (1977 p.109) writes that:

"The population represents not only the political base of perceived need, to which all politicians and all social services must sooner or later be responsive and accountable, but also the only scientific base usable by the planner to evaluate and compare health care systems objectively in time and space among different populations".<sup>1</sup>

The pattern of population distribution in Zimbabwe as observed earlier in the study is such that 80 per cent is rural and the remaining 20 per cent urban. Of the majority African population 85 per cent is rural whereas for the whites 95 per cent is urban. The problem of provision of health care facilities to urban and rural areas was carried over from the early settlement days and characteristically followed racial patterns. The urban areas were favoured with financial, material and human resources. This is not to say that some rural populations did not benefit from urban provision but merely to acknowledge the distinct difference in provision levels between the services provided in rural and in urban areas. It is the view in this study that

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1. Quoted in Lenneiye, M.N. (1980) Ph.D. Thesis, Bradford University.

the previous governments approach of providing a few district and rural hospitals poorly manned, to supervise some clinics if and when district councils constructed them in the rural areas, amounted to deliberate abdication of responsibility for rural health provision; which was politically inspired. This penalised the most needy in the remote parts of the country. On the basis of availability models, this practice limited the use of services by rural populations. Whereas Maurice King (1966) shows that utilisation of a health facility decreases the further one moves from it, it is also worth adding that the size of the facility, the range of services it performs and how well it performs them together with how well it is served by the transport network; effectively widen its catchment area. The manner in which government health facilities were located for the convenience of administrators and the manning levels maintained (there were few doctors in district hospitals which were mainly staffed by medical assistants) did not add much to their effectiveness hence their catchment areas remained small to the exclusion of a large rural population.

The provision of district clinics to screen patients and treat minor cases as outpatients would have had the dual advantage that people do not have to spend their hard earned income on transport to a distant hospital for a simple treatment, and the hospital does not have to spend costly resources on an ailment that



can be treated cheaper and quicker at the periphery. However leaving the task of constructing these to district councils was a sign of lack of sufficient concern for rural health by the Ministry. With the present number of these units at 450, an average of one per 13000 rural people is arrived at. Given the unequal distribution (See Map ) some areas, are literally devoid of health services.

Because of their perceived contribution to the economy, the urban workers were better catered for healthwise. Municipalities and Town Councils were legally obliged to provide health services to the African and European urban residents. The urban-rural bias was therefore a deliberate political creation based on the assessment of the economic contribution of the areas. With the liberation struggle, most of the rural facilities were destroyed or damaged. In Charter district, one out of the 19 clinics was undamaged although it was also closed for at least a year.<sup>1</sup> By comparison, urban services remained operational. When the free health service was introduced from September 1980, for those earning \$150 or less a month, the urban workers benefitted more because they had the facilities. For the rural areas, attendance trebled

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1. A field survey I did in June and July 1980 disclosed these findings more of which are discussed later in the study.

in those areas where a service was available, but for most, the lack of the facility itself meant that no advantage of fees removal could be taken - the situation remained one of nil availability; nil utilization.

The question of how rural populations have managed needs to be answered. The role of traditional practitioners in the African community has been up until independence unduly underplayed. At least one in two people consult a traditional practitioner before, after, or without going to a clinic or hospital. This means that, although unknown, the volume of resources channelled into this practice is big. A recognition of its effectiveness in dealing with socio-psychological problems has the potential of enriching modern medicine just as the later can also enrich the former. The formation of an officially recognised Association of traditional practitioners signifies the beginning of beneficial exchange.

Whereas the clinics and rural hospitals which constitute the major facilities in the rural areas, excluding medical missions, are wholly manned by medical assistants, the general hospitals and central hospitals at the other end of the spectrum (based in the urban areas) employ expensive professional staff in a bid to provide the so called 'highest quality of care'. The major issue becomes one of how to justify first class

quality care for the 15 per cent urban population while the over 80 per cent rural population lacks the minimum of services.

A look at the distribution of doctors and nurses brings out the disparity more vividly (Table 6:7). Whereas in the main cities there is a doctor population ratio of 1:4000, the rural population has very little access to doctors with an average of 1:62000. Even this figure hides deprivation levels which include 14 districts with a population of 1.3 million people which had no doctor in 1981.<sup>1</sup> The nurses, especially medical assistants are the only providers of care in many rural areas, and yet a ratio of 1:2500 people per nurse exists as compared to 1:400 in Bulawayo. Finally, the use of hospital beds per population gives a rough measure of hospital care even if wide variations in quality exist eg between a bed in Parirenyatwa and one in a rural hospital like Chitando. A ratio of 1:430 people exists as a national average but extremes of overprovision and nil provision are common.

In Diagram 6.c I show the variation in patterns of facilities utilisation between the rural and urban areas, which as I have argued are based on differences in the delivery pattern prevalent in the country. Another

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1. Health Sector Review, (1981) para. 159.



TABLE 6.7

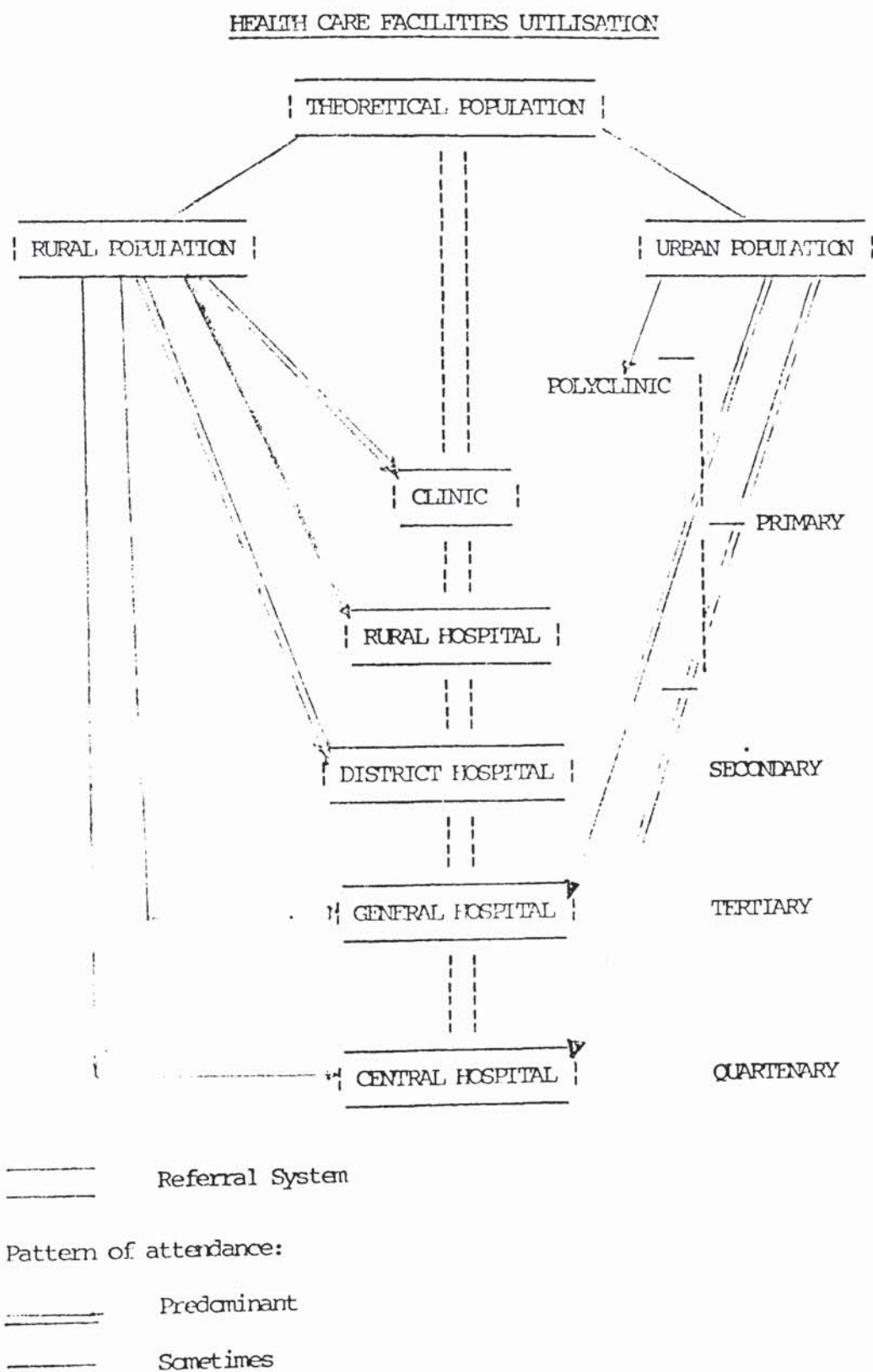
DISTRIBUTION OF HEALTH PERSONNEL BY LEVEL OF CARE (1981)

Levels of Care	Doctors		SRNs		MAs	
	No.	%	No.	%	No.	%
QUATERNARY LEVEL Central Hospitals Medical Schools	223	34	1136	51	432	15
TERTIARY LEVEL General/Special Hospitals	43	7	456	20	509	18
RURAL SECONDARY District/Mission Hospitals	45	7	159	7	629	22
RURAL PRIMARY Rural Clinics & Hospitals, P.M.O.H., Elair Laboratory Services	12	2	119	5	575	20
MUNICIPAL SERVICES Clinics, Infectious-disease Hospitals Environmental Services	14	2	187	9	477	16
PRIVATE Industrial and Private	316	48	174	8	265	9
TOTAL	653	100	2231	100	2887	100

Source: Compiled from HEALTH SECTOR REVIEW TABLES (1981)

Note: When read in conjunction with Diagram 6.c, the inequitable distribution of personnel resources (and, of necessity, other resources) in favour of the urban based services is fully noticeable.

DIAGRAM 6.c



Source: Adapted from Lemelie, M (1980)

Note: Because of the availability of high technology tertiary and  
6.c. quaternary level medical care, the urban populations seldom follow  
the referral path.



DIAGRAM 6.d

THE RELATIONSHIP AMONG DIFFERENT FORCES  
TOWARDS THE URBANISATION OF MEDICINE



Source: Vincente Navarro  
"CLASS STRUGGLE, THE STATE AND MEDICINE: AN HISTORICAL AND  
CONTEMPORARY ANALYSIS OF THE MEDICAL SECTOR IN GREAT BRITAIN"  
p. 96

problem which needs to be stated is the one of professionals unwillingness to serve in rural areas. This attitude is ascribable to the class nature of the recruits for medical training (middle-class and urban based), lack of incentives to work in the periphery and inferior conditions, poor back-up and inadequate supervision.<sup>3</sup> In the case of para-professionals, the equipment they use is only found in general and central hospitals. In short the training of these staff categories is in favour of urban practice. Community medicine is still being looked down upon as a specialty even within our Medical School. The distribution of specialists clearly shows the marked preference for urban practice, with 90 per cent concentrated in the two major cities alone.<sup>2</sup> The economic motivation and the preference for the social status that accrues to these professionals is seen to override the call to serve the most needy. The need for a political drive coupled with specific obligatory measures is seen to be long overdue.

As observed by Lenneiye (1980) on Kenya, it is those who least need government health services because they

- 
3. Navarro, Vincente (1976) as depicted in Diagram 6.d argues that scientific medicine and technology merely strengthen and legitimise a hierarchy and distribution of authority that already exists.
  2. Ibid para.133.

are better fed, have alternative delivery points (private care) - who are most provided for with them. Urban provision of health care has been and continues to be at the expense of rural health provision.

Whereas the mean cost of health care received per head by the urban population in 1980/81 stood at \$31.00 in the public sector, that for the rural population was \$4.00. The further away from urban centre's one moves the less the per capita expenditure on health, with 17 districts actually spending \$2.50 per head and two districts a mere \$0.50 per head. In the private sub-sector, the annual cost per head to medical aid beneficiaries was \$144.00, a ratio of 36:8:1 between the private, the urban and the rural populations.



(IV) INEQUITABLE DISTRIBUTION OF HEALTH SERVICES

The preceding section dealt with the bias in resource distribution in favour of the urban based, tertiary and quaternary levels which concentrate on high technology medicine and the cure of the diseases of affluence. Earlier discussions also demonstrated how the average cost of running a bed in the central hospitals in fact amounts to the cost of running a rural health centre serving 10000 people at a cost of \$10000.00 (see discussion under Medical Missions) per annum.<sup>1</sup>

Whereas it is true that the complexity of the problems dealt with at the sophisticated hospitals leads to the high costs, the fact remains that these facilities function less as central referrals than as secondary level facilities for private patients and local urban dwellers. The nature of these facilities distribution disadvantages the rural people with greater problems requiring serious medical attention. The present distribution pattern is best depicted by a dual axis (See Map 6.1) running along the highveld and joining the cities and towns. The one axis has its base on Plumtree, runs through Bulawayo, Gweru, Kwe-Kwe, Harare with its apex on Brindura. The other has its apex on Sinera

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1. Estimated annual expenditure per bed in central hospitals 1980/81 was \$11000.00. Health Sector Review 1981 Table 7.

MAP 6.1: THE DUAL AXIS OF HEALTH FACILITIES DISTRIBUTION.



Aston University

Illustration removed for copyright restrictions

through Harare, Maroudera with its base on Mutare. A small extension branches to Maseringo. For an area of 50 miles on either side of these areas, one can actually talk of over-provision of health services. This zone is the best served transport wise; with railways and all-weather roads; it has the best agricultural land; is the most productive in mining, commerce, industry and trade; and has all the central and general hospitals. It is no accident that 99 per cent of the white population is settled here. The majority of the African population (84%) lives in communal lands which are located as follows:

5% within 10 miles of the railway line,  
40% more than 50 miles from the railway line and  
having to depend on seasonal roads.

It is further notable that 35 per cent of communal lands are over 100 miles from the nearest town.<sup>1</sup> If this were to be related to the fact that 64 per cent of health services expenditure was concerned in Central and General hospitals 1980/81, and a further 11 per cent in District hospitals which are also located in towns and other small urban centres, with a few exceptions, the extent of the maldistribution becomes evident.

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1. See Chapter V Section II: Population: Distribution and Structure.



An analysis of health expenditure by district showed that district rural expenditure per capita ranged from \$0.48 in Clubi, \$0.76 in Mudzi, \$1.29 in Goromonzi, \$1.40 in Lupane to \$12.66 in Gweru and \$16.27 in Bulawayo thereby reaffirming the view that the further away from the area one moved, the lesser the care one is likely to get. The distribution of health care facilities bears no relation whatever to the need for health services. In fact an inverse relationship exists - the more outlying, malaria infested and climatically unsuitable the area, the less attention and health provision it received. This situation was made worse by the fact that these peripheral areas bordering the country were the worst affected by the war. A 'crescent area' of deprivation of health facilities is therefore discernible.

How did the population manage in the face of government neglect? Missionary provision which had 5000 beds catered for most of the rural areas from a budget that amounted to 3 per cent of national health expenditure. Their bed capacity is almost equal to that of central and general hospitals, the functions they perform to the recipient populations are the same, but the differences in resources available to them - \$48.3m for central and general hospitals and \$3.2m for Missions in 1980/81, illustrates the magnitude of the differences in care patterns. Is it then any wonder that only one-fifth of rural deliveries are at institutions despite 84 per cent of the population being rural?

The primary care service in the rural areas is done by clinics (see diagram 6:c) as opposed to the poly clinics in urban centres like Harare. The clinic is usually manned by a Medical Assistant and in rare cases by a Maternity Assistant. Some of these had holding beds, delivery beds and carried antenatal and post-natal care. The large majority of the 450 clinics were closed and damaged during the war. These do some referral to rural hospitals which are headed by a Principal or Senior Medical Assistant. There exists 46 of these throughout the country but unfortunately they were badly located to serve the administrative centres which tended to be located at the fringes of communal lands. In 1980/81 13 per cent of the health services expenditure was consumed at this level (the primary care level) despite it being the most accessible to the poor and the rural needy. Distances, poor roads and unwillingness of staff to work in these peripheral units coupled with poor drug supplies, lack of adequate equipment and insufficient supervision; meant that both the quantity and quality of health services was unevenly distributed in favour of the rich, urban based minority.

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(V) RACIAL AND ECONOMIC DISCRIMINATION EFFECTS ON  
ACCESS TO CARE.

When the urban-rural dichotomy in the provision of care is viewed in conjunction with the black-white population concentration in the rural and urban areas, whereby 84 per cent of the black population is rural as opposed to 5% white; the racial imbalance in access to care becomes clearer. An earlier comparison of annual incomes of the urban and rural blacks<sup>1</sup> showed a ratio of 5:1 which further favours the urban blacks. Race and economic means are factors in access to care.

Prior to the passing of the Medical Services Act, 1979, provision of health services for whites and blacks was segregated. At the central hospital level, Andrew Fleming Hospital (Parirenyatwa) and United Bulawayo Hospitals were white institutions while Harare and Mpilo, were black institutions. At each of the general hospitals, there was a separate wing for the white patients. Even at district hospitals, a room was set aside for use by white patients.

The services for whites were characterised by: better supplies of drugs and equipment, availability of specialists, a high doctor-nurse ratio, low nurse-patient ratio, low bed occupancy rates and good meals.

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1. Discussion under Chapter V, Income Levels.

The reverse was true of the services for the Africans: poor supply of drugs and equipment, lack of specialists, a low doctor-nurse ratio, high nurse-patient ratio, high bed occupancy rates and overcrowding (see Table 6:8).

The Medical Services Act 1979 redesignated the above classifications 'Open' and 'Closed' hospitals as part of the cosmetic changes aimed at pacifying the 'elite' African classes. A few rich Africans could now pay their way into the 'Open' wings of hospitals. The ulterior motive was the creation of a buffer group of 'elitist' Africans who would legitimise racist differentiation under the guise of economic means. At the smaller centres, District Medical Officers were still paid an allowance for visiting lone farmers or for going out 'on call'. Where the whites were concerned, distance was not a barrier to access to care.

The repeal of the Medical Services Act in 1980 was aimed at removing this differential access to care on the basis of colour or means. However the continued practice of private beds in government institutions, which numbered 1500 in 1981, which are manned by two-fifths of all the doctors in the country, has meant that the rich still have access to the best care. Despite the above, by careful design, the Government subsidises private care to the tune of 50 per cent, of its total cost amounting to a total subsidy of \$15 million a year. Private beds in government hospitals pay one third of

the cost, through their Medical Aid Societies contributions which are exempt from tax. In the final analysis, the urban poor who may seriously need medical attention or the referred rural patient, may be turned away because the hospital beds are occupied, while empty beds remain in the private patients wing.

In the light of the scanty to nil government provision of health facilities in most districts,, missions have been providing minimal services for which they have, until September 1980, been charging fees without even feeding the inpatients. While this situation prevailed in the needy rural areas, the government was spending \$1.019 million on the so called Government responsibility patients in 1981. These fell under two categories; those working or who have worked for the Government and also their dependents and widows, and "others" including prisoners, old age pensioners, South African old age pensioners, early settlers and pioneers and dependents, ministers of religion and members of Religious Orders, blood donors, Tuberculosis and Leprosy cases.

Commenting on the position of these patients Professor B Abel-Smith wrote:<sup>1</sup>

"The category of patients listed above as "others"

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1. Memorandum to Dr H S M Ushewokunze, Minister of Health June, 1981 on Government Responsibility patients.



is largely based on race - a privilege for Europeans. This was the origin of the category of employees and ex-employees".

Furthermore, in Government hospitals the instructions state that these patients should be given accommodation according to the "normal social environment of the patient", which is disguised racial discrimination entitling the white patients to be treated as private ward patients. Despite the fact that because of their economic ability they were contributing to Medical Aid, public funds have to be spent on them to which the rural and urban poor contribute. How many Africans could have qualified to be government employees?

Since independence, the Government's attempts at redistributing health care resources inevitably did not augur well for the privileged few who saw it as an intrusion into their private recluse. They sought alternative ways in the form of private hospitals. Proposals for two two-hundred bed hospitals in Harare and a one-hundred bed hospital in Bulawayo were submitted to the Government with an estimated capital cost of \$19 million. Besides being next to other, central hospital complexes, these would have further distorted the distribution of health resources vis-a-vis the rural areas. The government would have given an official seal to continued racial and economic discrimination in access to health care. With the accompanying drain on professional health staff, the economy would have been over-stretched to maintain

reasonable health services for the rural needy.

Despite the turning down of these proposals, race and economic means have, in the face of inadequate political resolve to curb their influences, enabled the minority to have excellent care at the expense of the large and inaccessible rural majority. This propertied minority continues to enjoy mean incomes and health resources approaching forty times those of the peasants, who suffer an infant mortality rate ten times higher.<sup>1</sup>

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1. Health Sector Review, 1981. para.166.

## THE INEFFECTIVENESS OF HEALTH CARE ORGANISATION

The World Bank indirectly referred to the possible contribution of good organisation of health services to health when it noted that:

"... the most persistent problems in improving health do not result from the complexity of medical technology, and only partially from the scarcity of financial resources; rather, they derive principally from problems in the design and implementation of policy, management and logistics."<sup>1</sup>

The major cause of these organisational problems has been identified by many writers on health organisation and administration as the dominance by physicians of the running of health services. They do not have the training and as observed in an earlier section of this chapter, Navarro unequivocally states that,

"... they do not have actual control of the structure of the health services".

They are mere agents controlled by the powerful external forces to the service. The problem then seems to be that physicians, if they actually do dominate the running of the health services, have failed to understand and direct the forces which interact in directing and controlling the health services.

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1. World Bank: "Health Sector Policy". February 1977.



Professor John Child<sup>1</sup> noted that external to any organisation there exists corresponding forces with strong influences on the different internal forces which press for the ascendancy of the line they support within the organisation. In fact he goes further to state that these play a key role even from the design of the organisation's structure. Conflict in organisations is endemic, the bigger they are the more the conflicts and the more complex they become.

The Ministry of Health is a complex organisation by its very size. The level of variety in it, ranging from the type and level of care, to the staff categories of specialists, professionals, paraprofessionals and ordinary workers adds considerably to the complexity within it. Each of the groups of personnel - doctors, pharmacists, matrons, sisters, nurses, medical assistants, technologists, administrators, dietitians, cooks, clerks, labourers, etc. - have their own group interests and have links with wider classes outside the Ministry. This is the systems view that every sub-system is a part of a wider system - social, political, economic, environmental or biological. Within organisations however each one group fights for its own cause often to the detriment of others and even of organisational goals.

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1. Child, John. "Organisation: A Guide to Problems and Practice". 1977.

Professor Child (1977) comments that:

"Any organisation has centrifugal tendencies, with individuals and departments straining to pursue their own chosen path. It is in fact a wonder that organisations hold together at all."  
(p.96.)

What structural mechanisms then existed in the Ministry of Health which enabled it to achieve its objectives prior to 1980?

Decisions on the type of structure adopted by the policy makers themselves as deducible from above, represent major items of policy. The basic structure itself is designed to suit prevailing powerful group interests. Organisational design is therefore a powerful process (Child 1977).

In the earlier sections, it was demonstrated that the health services were geared towards providing mainly curative services for the urban minority. Within this broad classification preferential care was shown to be provided to the white minority and the black elite. In Diagram 6e is shown the structural organisation of the Ministry. The Secretary for Health is the Administrative Head of the Ministry assisted by a deputy who is the Director of Medical Services. The latter is responsible for all other departments and units - PMOH's, Medical Superintendents, under-secretary for administration, Matrons, Laboratory Directors, etc. It is significant that the two top officials

should be physicians as are the PMOH's, Superintendents and other senior staff. In effect the service was being run by the doctors as a matter of course. Amatai Etziain quotes Dr Donabedin on the control of the Ministry of health administration by doctors as being based on the latter's behavioural superiority:<sup>1</sup>

"...the control of behaviour within the medical profession is brought about not by the coercive power of superior authority, but by the operation of ethical standards that prescribe responsibility to patients and sensitivity to the good opinion of colleagues .... It is asserted that most physicians are motivated to provide good care and to use the hospital in an appropriate manner. Deviations are believed to be caused by occasional inattention, ... bad habits or technical obsolescence, or by pervasive administration and organisational constraints over which the physician has little control."

The conventional view was that the physician was cut for the job and any failures were not his fault!

At the institutions level (see Diagram 6.f.) the Medical Superintendent headed central and general hospitals supported by a Matron and a Pharmacist Secretary. The 'triad', as it was called, had him at the apex overseeing everything with the Matron taking responsibility for nursing services and the Pharmacist Secretary seeing to the drug supplies and day to day administration. Specialists and other medical staff

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1. Education for Health Administration Vol.II p.6-7  
Selected Papers of the Commission, 1975.



related directly to the Superintendent. The nature of the health services emphasised curative care a clear indication of the dominance of the physicians. In addition, the administration and management form employed was geared to existing services, therefore any new policies undertaken could only be in response to external stimuli. The construction of the Andrew Fleming hospital complex which consumed 28% of the health budget in 1976, despite the pattern of our mortality and morbidity showing a need to strengthen preventive and promotive care; is an illustration of the strength of such political external stimuli.

No mechanisms for information sharing and joint consultation, data collection and analysis, for the whole health sector; including missions, industries, mines and municipalities, on a regular basis for actioning (except for notifiable diseases) existed. Even relevant health information from other ministries had no way of being speedily channelled into the ministry machinery. The Anthrax outbreak of 1980 demonstrated the lack of such mechanisms clearly, with the Ministry of Agriculture fully in the picture but Health in the dark despite the spread from animals to humans. Consultation, if it can be called so, took the form of monthly meetings by Permanent Secretaries. These were more familiarisation talks than meetings for managing inter-ministerial interface and co-ordination.

In the case of Council Clinics administrative responsibility lay with the Ministry of Internal Affairs while care supervision was by the PMOH but no formal consultative machinery existed. The PMOH's offices, based at provincial centres, were plagued by staff shortages, poor transport, bad roads, long distances and consequently poor drug supplies (even the system of ordering was very deficient) which made the level of supervision leave much to be desired. The Rural hospitals which were lociotionally better placed had no authority or the means to supervise clinics. They themselves were far from being adequately supervised. The District Medical Officers, who should have supervised them, saw their prime function as being to provide a curative service in the hospital not outreach work. Even the Health Assistants who were charged with promoting preventive work had no laid down formal links with health staff at clinics. This, coupled with the prohibitive size of the areas they had to cover, rendered them ineffective in health promotion in the needy rural areas.

By deliberate design, the Ministry employed a top-down mode of functioning whereby directives came from the top and reports flowed upwards. This over centralization meant that the people for whom the service should have been intended, had little to no say. Ministry sources noted that even building designs for care centres were required to conform to Ministry of

Works requirements! By contrast, the urban elite had adequate representation on Hospital Boards and even higher up through the Public Health Advisory Board. Administrative support by the Under-Secretary and head office staff was deemed necessary because of the need to set out clear rules and procedures and to minimise, prevent and control unauthorised expenditure. The need to ensure financial control accounted for the level of recognition given to the other personnel. Expenditure accounting in conformity with the budget, rather than resource allocation related to need was the major activity of the accounts department. Historical budgeting which works on adding a percentage to the previous year's expenditure, meant that the high spending medical sector (central, general and district hospitals) continued to absorb an increasing share of the health resources. The mode of planning in operation coincides with what Lindblohm (1965) called 'disjointed incrementalism' whereby the decision-makers made incremental adjustments where changes were required according to their interests. No longterm comprehensive view is taken of the health situation of the nation as a whole.

Clearly the nature of the Ministry's structural organisation limited its ability to co-ordinate its own activities and that of the other sectors that provide health care. Contrary to the popularly held



view that health systems should provide services and education as near to the homes as possible, the health care system remained top-heavy, centralised and inaccessible to the majority of the rural poor. Most importantly, the health system remained unresponsive to the expectations of the community. The lack of properly laid down and organised supervisory procedures and staff neglect adversely affected rural staff morale thereby resulting in poor standards of care.

The health care sector organisation continued to reflect in the mode of its operation, the power relations that existed across all the sectors of Government and in the broader socio-political sphere. Social class and political power influenced and determined the selective provision of care in the health services in this country prior to 1980.

## CONCLUSION

It has been shown above that despite a large increase in the resources allocated to the health care sector, which amounted to 4 per cent of the GNP in 1980, inequalities in health care provision persisted. The extent of these inequalities was viewed under the following section:

- (i) the fragmentation of the health care sector,
- (ii) the preventive-curative services dichotomy,
- (iii) the urban-rural dichotomy,
- (iv) the inequitable distribution of the health services,
- (v) racial and economic discrimination effects on access to care,
- (vi) the ineffectiveness of health care organisation.

The discussion further highlighted the need for changes in the socio-political and organisational system which determines the power relations and hence the allocation of resources. Whereas the previous chapter V dealt at length with the effect of economic and political factors on health status, this chapter has tried to argue that had the mode of distribution of health care resources been more equitable, the average state of health of the nation as a whole would be higher. Less fragmentation in the provision of care, which can only come about through a conscious political decision to

provide health care to all the population irrespective of social class and economic ability, would result in more resources being channelled to the needy rural poor. Increased integration of services would inevitably disclose the disparate distribution of resources to the primary care units and force increased rationalisation of resource allocation. This would show the need to emphasise preventive care which is less expensive and yields greater returns per dollar expended through improved health of the individual and the community. This would lead to the channelling of increased resources to the rural needy. Integration would further ensure that mechanisms are developed which promote the utilisation of appropriate technologies developed at relevant levels.

The ineffectiveness of health care organisation was as a result of a number of factors which included, race, the dominance of physicians, poor siting of health facilities, staffing patterns, unwillingness to serve in rural areas, poor logistical support, etc. The health services structures and the institutions mode of functioning were not themselves conducive to equitable provision. This was not by accident, it is because organisational design is itself a political process, in which the politically powerful, ensure that their interests are served and preserved.

Far from the health care sector assisting in closing



the gaping differences in health status, it has perpetuated them by overproviding the rich urban-based elites. Health care has not been accessible to the rural peasant and to the rural workers who comprise the majority of the population.

How then can these big differences in health status and in health care be removed so as to improve the average health of the nation? What planning methodology can address itself to the demonstrated deep-seated political, socio-economic and organisational problems which manifest themselves through poor health among the rural majority population? This is the subject of the following chapters.

PART III : CHAPTER 7

The frameworks of analysis examined in Chapter II, although they had some partial applicability to the situation in Zimbabwe at varying time periods, were inadequate in many important respects once the internal contradictions had taken an antagonistic turn which resulted in a bitter armed, confrontation. As methods of enabling understanding of political crisis situations, they had serious defects. Furthermore as tools for enabling one to design planning and complex decision frameworks, they had very little to offer especially under constantly changing or dynamic conditions. The need to establish stable outcomes over a time-path has led to the advocacy of the Metagame Analytic technique of Options Analysis as a suitable methodology for analysing the Zimbabwean conflict and therefrom planning for its development as a nation through improved health.

The method and technique are discussed in the first two sections. Then examples of application in the real world situation and the results are recounted before a discussion of the approach's advantages. The Chapter is divided as follows:

(i) SITUATING THE PROBLEM

Why was it necessary to search for a new methodology?

(ii) METAGAME THEORY: THE TECHNIQUE OF ANALYSIS  
• OF OPTIONS.

(iii) THE USE OF METAGAMES

(a) The International Game (1979)

(b) The Policy Level Games - Political  
stability after independence.

(iv) DISCUSSION OF ADVANTAGES OF ANALYSIS OF  
OPTIONS.



PROPOSING A METHODOLOGY : METAGAME ANALYSIS - THE  
TECHNIQUE OF ANALYSIS OF OPTIONS

(a) SITUATING THE PROBLEM

It was established through the empirical historical analysis of the country in Parts I and II that there is a need to develop a method of analysis that attempts to place political factors at the forefront of the planning activity. More than that, the main objective of the study is to propose a Planning and Management model. It is therefore imperative that the nature of the future state, the form it is to take, be established before the mode of Planning can be proposed. Throughout the study, I have made the point that political motivations and requirements dictated the pace of all other activities in the Zimbabwean situation. This runs contrary to Marxian conception whereby the material base sometimes 'determines', 'conditions' or 'corresponds' to the super-structural factors noted as political, ideological or socio-cultural.<sup>1</sup>

It is central in this study that the point which the conflict, (the inevitable conflict that was the result of the inequities discussed in the foregoing chapters)

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1. This is discussed in Chapter II, under the section: "Marxist Theory of Imperialism and subsequent analyses".

had reached in the period 1972-1979, be analysed in an attempt to determine the possible political outcome that was to be the major determinant of the Planning and Management model to be adopted for health. This was consistent with the proposition made in this study that health can be 'an entry-point' and indeed is, 'a potent lever' for development; as defined in Chapter II.

As shown in earlier chapters, the political conflict in Zimbabwe had reached a crisis level. Nowhere was this more pronounced than in the African population's state of health. Health as we observed in Chapter II is a barometer of the state of affairs in a given country. But, could it have been possible to tackle the health issues before the broader controlling factors had been examined? The discussions in Chapter V and VI seem to indicate that this is not feasible. Politics primarily determined the wider framework, within which sector planning was made possible. Determination of possible political outcomes therefore became a priority in our search for a health planning model that would ensure 'the growth to fullness' of the Zimbabwean people that is development.

Under the section on "Defining Development", in Chapter II, I noted that;

"The power of the external political, economic and social forces on UDC's, ... is considerable. The major political and economic structural transformations required in them before they can develop are considerable, because they lie at the very basis of international relations".

Before examining the "Political Economy of Rhodesia" I further viewed the wider framework within which an individual country should be examined. Most relevant were the issues that dealt with the country's place in the international economic system. International capital used political muscle to impose itself. In Zimbabwe's experience, political imperatives initiated economic moves.<sup>1</sup> These imperatives laid the basis for links which played a crucial role in the form that our conflict took. To a very large extent, Southern Rhodesia presented a deviation from the normal pattern of colonisation, exploitation and dependency. This was brought out clearly in our discussion in Chapter III wherein we showed that the agents of imperialism, the settlers; became the national bourgeoisie.

Rather than aligning with the traditional dominant classes, they confronted them; instead of cultivating an indigenous elite, the settler class saw it as a challenge and since they had the power, they took

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1. This is dealt with at length in Chapter I, under the section on "European Settlement".



measures to crush it. This left the dominant settler class in conflict with; the imperialist colonial power and the local representatives of monopoly capital on the one hand, and the indigenous elite and the dominant class whose land they grabbed and whose people they forced into labour, on the other hand.

Our historical analysis showed how the power struggle proceeded over the years and concluded that:

"... the central dynamic of the UDC's lay outside their economies and that options open to these peripheral economies are limited to the development of the system at the centre. It is in this context that the particular development of a nation within a system .... .... the need to understand the alignment of the general forces in the international system, will call for an international analysis in the process of situating Zimbabwe as a country and how it is affected."  
(Chapter II p. )

It is deduceable that international capitalist relations impose conflict on underdeveloped nations<sup>1</sup> through their imposition of laws, customs, and ways of life alien to the country and their disregard of existing cultures, structures and institutions. On that basis, settlerism created conflict in Zimbabwe. At various stages of the country's history, attempts were made to resolve this conflict. The

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1. Rhys Jenkin, 1977, p.139.

history of the country up to the mid-sixties, saw a gradual if not ragged build up to confrontation between the settlers and the majority African population who wanted a political say as a prelude to economic benefits.

The settler rejection of external political control by Britain through the declaration of independence in 1965, and their drive to direct and control the economy, thereby confronting international capital from the post World War II period; put Southern Rhodesia in an interesting position for analytical purposes given the hitherto available framework. Here was a bold attempt at industrialisation in the periphery, following upon rejection of external political and economic control. A form of sub-regional affiliation to South Africa was developed, rooted in the dominant classes, (in both countries) conviction in racial supremacy.

Marx did recognise that:

"Whether exogenous or indigenous ... once implanted in a society, capitalism will develop in a certain way. If one of its central characteristics is to develop both objective wealth and poverty, this would exist within each society rather than between societies."<sup>1</sup>

- 
1. This is discussed in Chapter II, under the "Marxist Theory of Imperialism and subsequent analyses".

At least he accepted the possibility of autonomous capitalism in the periphery and further pointed out that,

"the accompanying problems of inherent contradictions will also be imported ....  
.. its acceptance sharpens the contradictions".

What remains questionable in Marxist thought as applicable to Zimbabwe was the importance of the role played by the traditional dominant classes in the country. I showed in Chapter III that under Responsible Government in 1923, African rights to land remained the preserve of the Crown. Whether one could confidently say this constituted 'the feudal-imperial-alliance' referred to in Marxist analysis remains questionable. What came out clearly in Chapter III is that the national bourgeoisie developed the political capacity to assert themselves over the indigenous population - traditional authority and the indigenous elite included. The national bourgeoisie went further and enacted legislation that effectively controlled the operation of international capital. To solidify their doctrine,<sup>1</sup> they co-opted the white working class into their ranks by offering them some political say and economic incentives through legal protection from African

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1. See Chapter III, "Growth of Classes and Conflict".



competition, and high wages. (Chapter III p. ). In return, the white working class guaranteed them political power. The Rhodesian white national bourgeoisie, was prepared to make economic concessions in return for political power. It was convinced that political power reigned supreme.

At varying points in time, international capital switched allegiances to suit its profit motives, which complicated attempts at using conventional methods of analysis to understand its patterns. What remains unquestionable is that international capital continued to play a role albeit often a shackled one. When it saw fit, it tightened the screws on the national bourgeoisie to extract concessions. In short Rhodesia remained dependent on the international capitalist system which continued to export surplus value to the Metropolis which had a continuing interest in the country as shown by the Birmingham Report of 1978. This report disclosed that despite the United Kingdom being the mover of the U.N. Resolution 514(v) on Southern Rhodesia in 1966 which imposed mandatory sanctions, British Companies continued to trade with it directly or through holding companies in South Africa. The U.S. as head of the capitalist world, the so-called free world, through the Byrd Amendment also traded with Rhodesia. True to form, economic imperatives led to the adoption of contradictory policies by the Western Countries whose implications will be brought out more clearly in the analysis to follow.

The above establishes the need to analyse powerful forces external to the country before tackling the internal ones locked in a conflict. This is because of the structural links that exist between the external forces and the internal ones despite attempts at severing them. These links reflect one another in their compatibilities and contradictions. They also determine the extent to which,

"a particular economy is articulated with the centre and how its specific dynamism are thus generated." (Palma, 1978).

This form of analysis which takes into consideration historical realities, provides the nearest the dependent developmentalists got to offering a framework of analysis to the situation that existed in Zimbabwe at the peak of the armed struggle in 1978-1979.

The chronology of events over the period to 1979 has already been examined. It is considered adequate to state here that contradictions had sharpened to the point where a bloody war was being fought. Each side had its own supporters, so the international forces realigned in a confrontation that created a crisis situation in Zimbabwe. As the war wore on, there was a need to design methods of analysis which would enable; determination of possible outcomes of the confrontation and embarkation on some planning for the restoration of the nation to health.

Where did the conventional forms of analysis fall short? Put differently, what aspects would the proposed methodology attempt to tackle, which the former failed to fully or sufficiently cover?

Without labouring the point to which I will return later on in this chapter, they failed to give an indication of the possible outcome of the conflict in terms that would have enabled one to set-out a planning framework for health. They did not offer a composite 'moving' or 'progressive' model that would have enabled one to perform continuous analyses of the developments inside and outside the country. As general frameworks, they lacked the ability to breakdown into smaller and more specific forms of analysis to be applied to a specific country with a particular history, own relationships and own class structures. As tools for planning, they lacked viability.

It is in the light of the above short-comings and others observed in earlier discussions, that the Metagame method, through its technique of Analysis of Options, is proposed as a relevant methodology. It will now proceed to view it.



(ii) METAGAME THEORY: THE TECHNIQUE OF ANALYSIS  
OF OPTIONS.

The theory is a re-interpretation of mathematical game theory.<sup>1</sup> It:

"adds to game theory some new concepts including even the concept of 'metagame'; and a degree of unification. Most importantly however, it is a re-interpretation",

of game theory.<sup>2</sup> This has been observed to make the theory an 'applied mathematical theory'.

Mathematical game theory originated by Van Newman and Morgenstein provided an elegant mathematical analysis of the 'two person zero sum' situation. Unfortunately it is not able to deal with even a moderately realistic conflict situation with several players which are not zero sum. Most crucially it cannot deal with the sequential nature of conflict situations. For many years this created a theoretical impasse, until metagame theory was created. It is a theory about certain aspects of 'political behaviour' which, if defined broadly,

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1. Howard, N. "Paradoxes of Rationality: Theory of Metagames and Political Behaviour". M.I.T. Press, Cambridge, Mass. 1971.
  2. Howard, N. in Introductory Notes to "The Arab Israeli Conflict", 1972 p.4.

include conflict of interest situations in business, daily life, community life or politics.

The theory assumes that players are in general not rational in their behaviour; they choose to proceed along an unpreferred alternative. Since decision makers are the players in a decision situation, they are irrational. The theory analyses the game as it appears to the players; their subjective game is viewed as the unique game which they fully understand. It is that which produces behaviour. By so doing, metagame rejects 'optimality' in favour of metarationality as a course of action for a decision maker in a political situation; because:

"game theoretic decision problems are unsolvable".<sup>1</sup>

This is so because the outcome of a player's decision depends on other players' (or decision makers') actions and the set of players cannot solve their problems because their preferences conflict. What then the game does is make predictions about a situation which concern the 'stability' of various outcomes. It explains, analyses and predicts stability in a conflict situation. It does not recommend a specific course of action. The decision maker has to decide for himself what to do after

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1. Howard, N. 1972 p.60-61.

an explanation of the predicament he faces. 'The paradoxes of game theory make it impossible to recommend courses of action to a decision-maker'.<sup>1</sup> One can only explain the situation through the prediction of certain relationships between the decisions of different players and their expectations regarding the policies and reactions of the others.

K.J. Radford (1977) defines a metagame as a hypothetical situation that would arise if a particular player knew the choices of options and strategies of each of the others involved.<sup>2</sup> The knowledge of each other's options and preferences by the participants, leads to the attainment of outcomes (meta-equilibria) that might not have appeared as such in the original game.<sup>3</sup> Meta-equilibrium is a position that can be jointly sought by participants who wish to obtain some stability in a conflict situation. It does not represent a national solution to problems arising in that situation. This is attributable to the fact that, in a decision situation, the choice of options depends on the attitudes and behavioural characteristics of all participants.

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1. Howard, N. 1972 p.66.
  2. Radford, K.J. "Complex Decision Problems: An Integrated Strategy for Resolution". 1977. Reston Publishing Company. p.78.
  3. Radford, K.J. "Managerial Decision Making", Reston, Virginia. 1975 p. 136-145.



The application of metagame theory is:

"an event in which a task force of certain persons involved in a particular conflict situation and a metagame analyst participate."<sup>1</sup>

For the task force, it is a discussion of a conflict problem - in our case the Zimbabwean conflict - over days, weeks or months. The task force membership has inside knowledge of the problem. These should be actual decision makers or failing which people in an advisory capacity to them.

Metagame Analysis differs from ordinary discussions among policy makers, politicians or managers in that it uses the technique called - Analysis of Options. Under this technique, the decision problem to be analysed is viewed as a game situation; below I view the analysis progression. The analysis provides a method of determining which of the present or possible future scenarios can be regarded as stable,<sup>1</sup> thereby offering possible grounds for resolving the problem. When carrying out the analysis, the Analyst's contribution is purely procedural therefore he need not know anything about the particular conflict under analysis nor do the task force members (the players), need know anything about the method.

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1. Howard, N. "The Arab-Israeli Conflict: A Metagame Analysis". Published in Papers, Pearce Research Society, Vol XIX, 1970.

SCHEDULE 7.a

METAGAMES

Use of Terms

**PLAYER:** A decision-making entity that has its own objectives and some incomplete power to influence the outcome. Usually an organisation not, as in the ordinary sense an individual. In general, "every player is a game", meaning - that the options and preferences of a player result from an internal game within that player.

**AN OPTION:** A variable (binary) representing a "yes-no" policy alternative controlled by one player. A value of 1 means "yes", the option is taken; "0" means it is not taken. A dash "-" means "yes or no", either 1 or 0 may be inserted. An option may be decomposed into sub-options (a follow-up part).

**INFEASIBILITY:** A condition ruling out certain combinations of option values as infeasible. These combinations may be logically or physically impossible or simply not worth considering. Such a condition may be said to be vacuous.

**COALITION:** A subset of players usually designated C.

**STRATEGY:** A statement of intent indicating whether or not a player will implement each of his options.

**SCENARIO:** A combination of option-values or strategies covering all options - i.e. a strategy N represents a possible future history of the situation. A scenario is stable if it is stable for each player separately. In practice, scenarios generated by a player are based on his perception of the problem and on his perception of the other participants' available courses of action.

**PREFERENCE:** A non-quantitative relation between scenarios. A player prefers A to B when his internal game would lead him to choose A if the choice were open. A player's preference may or may not accord with his objective interests. (Given two bad situations, you may prefer the one to the other although it is not to your objective interests).

**UNILATERAL IMPROVEMENT:** A move from a particular scenario A to another scenario B such that (i) the options of N-C are unchanged when N-C represents non-coalition players, (ii) all players in C prefer B to A. A situation where a particular player improves his position by acting unilaterally - the strategies of other players remain unchanged.

**GUARANTEED IMPROVEMENT FOR C:** A unilateral improvement that remains preferred for C regardless of the values taken by the options of the players N-C (i.e. non-coalition players). It is a move that is better for a player whatever the others may do in terms of choosing from their stated available options.

**SPECIFIC SANCTION:** (against a specific unilateral improvement by C to B from X). A strategy of N-C (non-coalition players) such that if the players in C keep to their strategies in B, the result is not preferred to X by some players in the coalition.

**GENERAL SANCTION:** (against any unilateral improvement by C from X). A strategy of N-C such that, whatever strategy is chosen by C, the result is not preferred to X by some member of C. It deters a player from moving away from the present or considered situation or scenario and results from the action or actions of other players in the game.

**AN OUTCOME:** A column of "1", "0" and "-" represents it, if written against the options available to the players. It should be interpreted as a time-path of future events with probabilistic elements. It represents the probable future, given the specified options are taken and not taken.



### ASSUMPTIONS:

Before proceeding with the game, a set of working assumptions has to be drawn. (See Schedule 7.b.). These help map the parameters and provide the substantive working material - facts and information about the nature of the conflict. They are the basis and guide of the analysis. In them are stated the main factors leading to the choice of a particular option or why a certain situation is considered stable. They need not imply any preference ordering - furthermore the players can change them - add on or subtract from - as the game progresses. This may be because the facts on which they were made, might have changed. This flexibility is an advantage.

### GAME PROGRESSION

The game progresses in steps, this can be shown in the form of a flow chart as in Diagram 7.i. In addition to recording the analysis, the analyst prepares a report at the end of the exercise which the decision makers may or may not use as the basis of their decision on the complex problem. In the following section the application of the technique at the international level is demonstrated in a study of the Zimbabwean conflict.

SCHEDULE 7.b

LIST OF WORKING ASSUMPTIONS

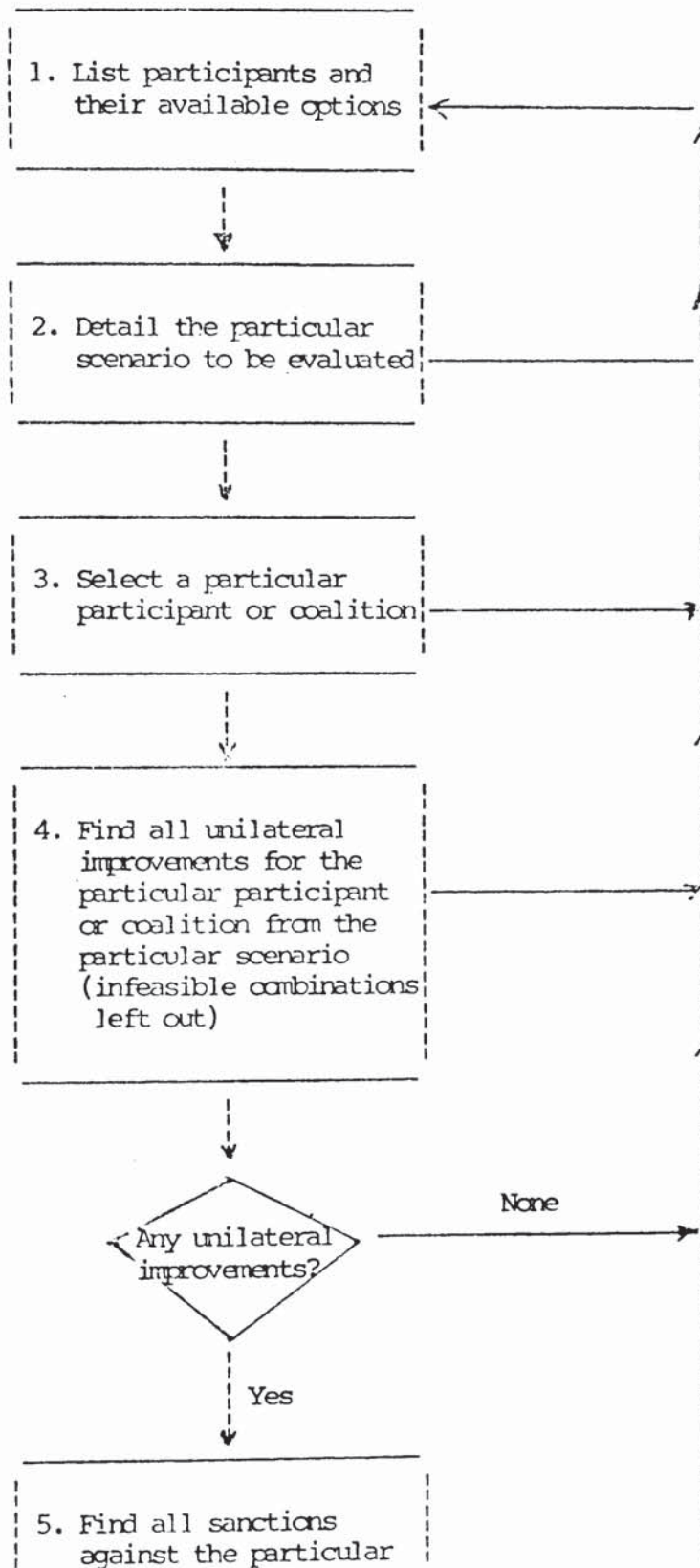
1. The growing strength of ZANU (PF) pointed to a ZANU (PF) dominated victory within two years. This was based on its mass politicisation programme, the size of occupied areas within the country, superior number of armed and infiltrated fighters, a stable base, a successful propaganda machine and a dynamic and broadly based leadership which clearly articulated socialist goals.
2. That S.A. has an option to increase support to Rhodesia unilaterally (without the S.U. increasing its own) and they see themselves securing the Rhodesia-Zimbabwe government which is favourable to them as part of their Southern African block. They see this as a strategy to stop communism.
3. The present situation will lead to a PF victory, without massive or increased Soviet help, in a few years in the S.A. view.
4. That S.A. would not prefer a situation where they are fully supporting Rhodesia-Zimbabwe while the Soviets were also pouring support to the PF.
5. That the Chinese, though dependable supporters of the PF (especially ZANU), would not step up their support to the PF to match a heavy increase by S.A. of support to R-Z. Even if they did try, logistical problems and the time factor mean a delay which S.A. would prefer to the present situation - which is steady victory by the PF. S.A. keeps hoping that a change of Government in the US and the U.K. may come about which would support them. So it welcomes whatever move would buy time.
6. If S.A. increases of support were matched by the S.U., the West would not prefer to increase its support for the Internal Settlement (Z-R). This is based on US policy on human-rights, a post-Vietnam experience mood in America which would see public opinion rise against the government if it is seen to back an oppressive regime or to intervene in the affairs of other countries.
7. That the US+West's passive support for S.A. could not realistically be withdrawn to a great extent because the international economic system is such that it would be impossible to stop the selling of arms to S.A. Politically as well, countries like France and Israel might continue to pour in military technology for the reasons that they would like to make friends. Internal influences, including pressures to open new markets may force countries like Japan to trade with it. In addition, withdrawal of passive support would still leave S.A. in a preferred position because of its already acquired strength which continues to increase the more beleaguered it feels.

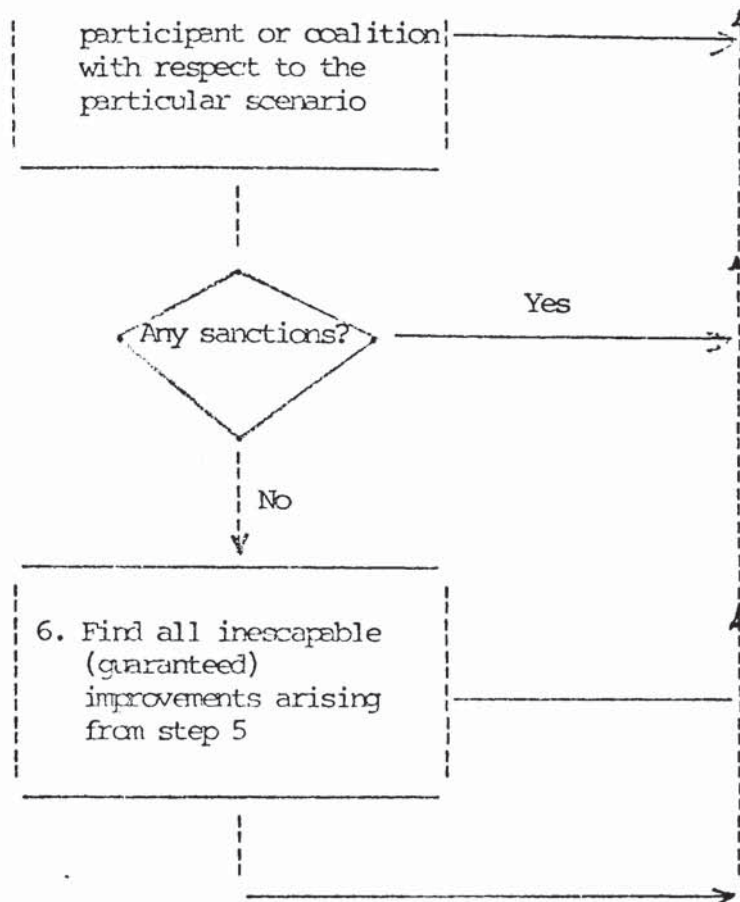
8. The combination of US full support, East-West confrontation plus Rhodesia not fighting would mean that the US will set up a regime to support. This would be along the pattern of Vietnam.
9. That the West would never give military support to the PF to fight in Southern Africa because the Whites therein are its kith and kin. In addition, it has huge investments there. It is only logical that the PF has to turn to the Eastern bloc countries.
10. The public opinion in the West is opposed to 'Soviet expansionism'. Therefore, it will drive the West to confront SU if it comes face to face with S.A. (This escalation to US+West confrontation is not a guaranteed improvement for S.A. because it is not under its control.)



DIAGRAM 7.i

PROCEDURE FOR THE ANALYSIS OF OPTIONS





It is important to re-emphasise that stability in any given conflict situation is always sought because it is the starting basis of an analysis. It is the situation accepted by both parties willingly or unwillingly. For an option or a course of action to be assessed, it must be related to the stable situation. The analysis therefore usually starts with consideration of the present situation as seen by the players.<sup>1</sup> It is important to restate that the theory in Metagames predicts an outcome only if that outcome is stable.

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1. Radford, K.J. "Complex Decision Problems".  
Op.cit. p.79.



## THE ZIMBABWEAN CONFLICT ANALYSIS

This analysis was carried out between March and May 1979. (See Espejo, Howard and Mugwagwa (1981)).<sup>1</sup> The desire to determine from the events what the possible future outcome of this conflict could be, and thereby use that as a basis for future health sector plans, prompted the analysis. The analysis follows the procedure shown in the flow diagram 7.i, but it is important to note that complete documentation of the analysis is not possible because of the sensitivity of the analysis, its length and its somewhat repetitious nature. Here I will try to show the essential aspects of the method as disclosed through its application in the Zimbabwean case, so as to enable some understanding of its functioning. More detailed material as regards its derivation can be obtained from published works.<sup>2</sup>

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1. Espejo, R., Howard, N. and Mugwagwa, N.O. (1981) : "The Zimbabwe Revolution: Before and After Independence". Working Paper No. 225, University of Aston in Birmingham.
  2. Published works include: Howard, N. "The Arab-Israeli Conflict: A Metagame Analysis Done in 1970". Peace Research Society Papers 19.  
Bain, H., Howard, N. and Saaty, T.L. "Using the Analysis of Options Technique to Analyse a Community Conflict". Journal of Conflict Resolution 15 (1971).  
Alexander, Joyce M. "An Operation Analysis of Conflict in Northern Ireland: An American Perspective". Journal of Peace Research 13 (July 1976).  
Howard, N. "The Analysis of Options in Business Problems", INFOR, The Canadian Journal of Operational Research and Information Processing 13, No.1. (February, 1975).

The proposition I made at the time of the analysis was that the Zimbabwe African National Union (ZANU) in the Patriotic Front alliance (PF) would win the armed struggle in two years or so, 'if the existing situation remained as it was'. The task force, through discussion, had to determine what 'the existing situation' was.<sup>1</sup> It is this situation which will be analysed for stability, following the procedure of Analysis of Options. In the game terms, the existing situation to be analysed is termed the 'present scenario' or the 'particular scenario', as per the current policies of the players as specified in Schedule 7.i.

The 'current or present scenario' provides for a review of a range of possible future scenarios taking into account all the players and the best information on their options and their preferences for outcomes.

(Radford (1977) p.79). It must therefore be analysed for stability for each player or coalition of players.

The current policies are determined through lengthy

- 
1. The 'task-force' comprised of: David Cligodora, David Karimanzira, Emmanuel Fundira, Ganyanhewe Masanga, Greenfield Chilongo and Norbert Mugwagwa, who were all ZANU (PF) members in Official Birmingham Branch and UK District Executive positions. They could be termed to be in advisory positions then and in the future unfolding of events. Mike Luck was in attendance and Nigel Howard was the Analyst (I doubled with him as part of the study process).



SCHEDULE 7.a(i)

IDENTIFYING THE RELEVANT PLAYERS AND OPTIONS

PRE-LISTING OF PLAYERS	ASSESSED AS THE EFFECTIVE PLAYERS	OPTIONS
UNITED NATIONS (U.N.) UNITED STATES OF AMERICA UNITED KINGDOM (U.K.)	(A) WESTERN POLICY (U.S. + WEST)	1. PASSIVE SUPPORT 2. FULL SUPPORT
SOUTH AFRICA (S.A.)	(B) SOUTH AFRICA	3. FULL SUPPORT
ZIMBABWE AFRICAN NATIONAL UNION (ZANU) ZIMBABWE AFRICAN PEOPLE'S UNION (ZAPU)	(C) PATRIOTIC FRONT (PF)	5. FIGHT
SOVIET UNION (S.U.) CUBA	(D) SOVIET UNION	4. FULL SUPPORT
UNITED AFRICAN NATIONAL CONGRESS (UANC) AFRICAN NATIONAL CONGRESS (ANC) RENKESIAN FRONT (RF)	(E) ZIMBABWE-RENKESIA (Z-R)	6. FIGHT
TANZANIA MOZAMBIQUE ZAMBIA ANGOLA BOTSWANA	FRONTLINE STATES	
ORGANISATION OF AFRICAN UNITY (O.A.U.) CHINA	(F) CHINA	7. SUPPORT 8. MARCHING SUPPORT (If — 3)



discussions of the task force which are summarised in the list of assumptions - Schedule 7.b. drawn by the analyst, who is constantly structuring the problem through questioning the players to establish substantive points. The list is agreed and constantly updated in conjunction with the task force.

A scenario is designated by a column against options, of '1' for yes an option is taken, '0' for an option is not taken and '-' for either taken or not taken. In this analysis, taking an option by the important players - S.A. and S.U., whose change of policy would change the proposed outcome; meant giving 'large scale support' to their coalition partners Z-R and PF respectively. In the simple model (Figure 7.1) is shown the resultant situations (scenarios) from the changes in policies of the two players.

In Step I, the task force decided on the list of players and options. For the West, 'passive support' is viewed as that which it would be impossible for the governments to curb - like trade as was going on despite the sanctions, or support group activities. 'Full support' would mean large scale military intervention which would mean a global conflict. The same applied for the S.U. which currently favoured ZAPU in the PF alliance. 'Full Support' by S.A. would mean a massive open involvement that exceeded its presence to date. Its willingness to do this was shown during the internal settlement elections of 20th April 1979. China would

FIGURE 7.1

FOUR SCENARIOS IN THE SIMPLE MODEL

SOUTH AFRICA (Large scale support)	0	1	0	1
SOVIET UNION (Large scale support)	0	0	1	1
	↑	↑	↑	↑
	Current Scenario	Internal settlement secured	Patriotic Front victory with Soviet help	Dangerous escalation

attempt to step-up its support to ZANU in the PF alliance 'if' S.A. moved to 'full support', although this would be governed by the Chinese philosophy that 'we give you one gun, use it to capture more from the enemy'. Z-R and PF have 'fight' options because it would be infeasible for their backers to 'full support' them if they were not fighting each other.

The scenario to be evaluated for the different players and coalitions, my stated proposition, is that ZANU (PF) within the PF alliance, would score a military victory within two years, if the current policies of the 'players' remained unchanged. (For steps 2,3,4,5, and 6, refer to the tableaux, figures and diagrams as stated). The analysis is intended to examine the stability of this proposition. This is done for each player or coalition of players. Through assessing whether each one in turn has a unilateral improvement away from the scenario, for which there is no credible sanction which the others can invoke, one is able to determine the stability or otherwise of the scenario. Such a unilateral improvement is guaranteed or inescapable and invariably leads to the conclusion that the scenario under consideration is not likely to be stable.

The analysis proceeds to consider all the scenarios that can be constructed from the options of the particular player (P/P) and, from the discussions of the task force, a judgement is made as to whether the new scenario would be 'preferred' or 'not preferred' to the

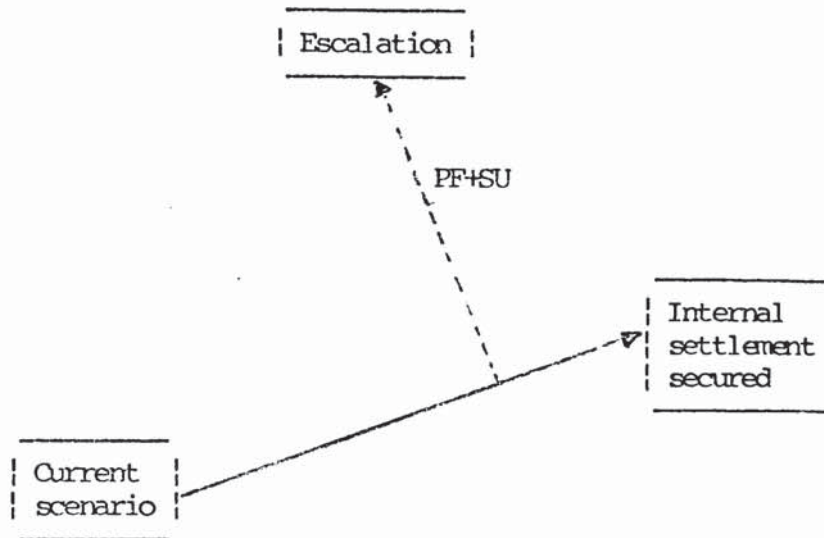


'particular scenario' (P/S) - ie a ZANU dominated PF victory. While a P/Ps options are being considered, only his values (O,-&1) are varied. The other players values are held constant. The judgement as regards preference is made by the task force to the best of their ability.

In Tableau 7.1(i) column (1), SA is the P/P. The particular scenario (current scenario), ie a ZANU dominated PF victory, is entered in the middle column. SA would want to move away from this situation. It may decide to move to 'full support', which means full-scale military intervention, to secure the internal settlement of Ian Smith and Bishop Muzorewa following the 20th April, 1979 elections. This is designated on the tableau by inserting a '1' on the SA option to the left of the P/S column and a '0' to the SU option. The dashes for the other players options mean that SA prefers this move whether or not those players change their option values. This unilateral improvement would provoke the SU to give 'full support' to the PF, a move which was assessed and found to be credible. SA as shown in the tableau would not prefer this to happen; therefore it is a valid sanction. A simple way of showing these 'moves' which are not real moves, but 'negotiating' moves as we noted earlier, is by using strategic diagrams. This is shown in Diagram 7:ii. This shows that a SA move to secure the internal settlement would result in Soviet intervention and an 'Escalation' of the war. This should deter SA from the move 'full support'.

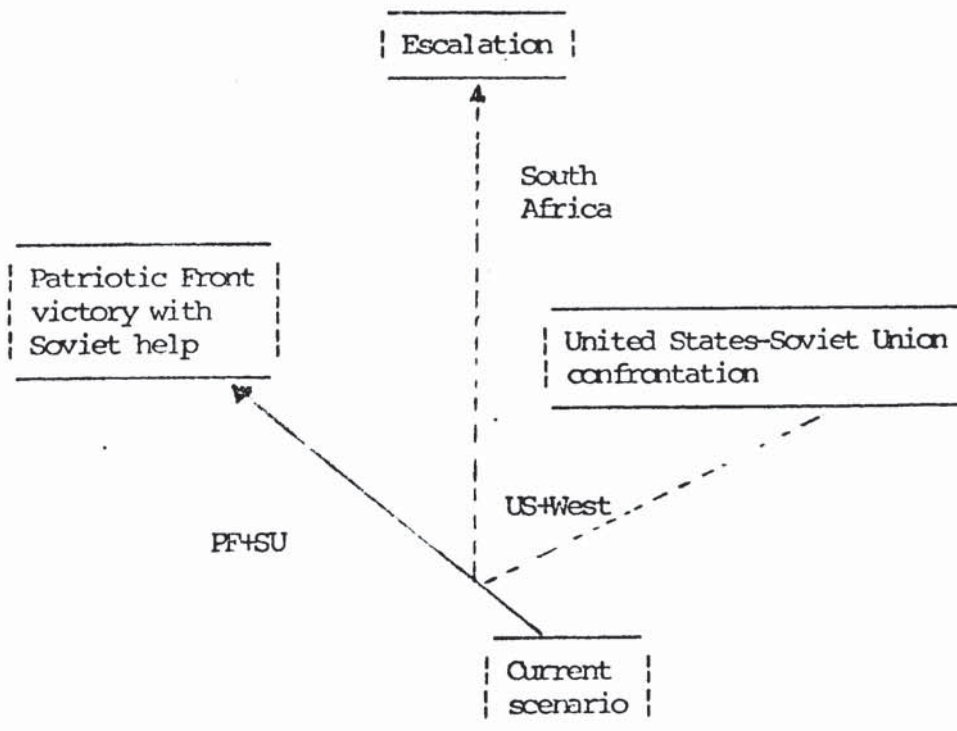
STRATEGIC DIAGRAM 7.ii

UNILATERAL IMPROVEMENTS BY SOUTH AFRICA FROM  
CURRENT SCENARIO AND SANCTION BY PF + SU TO DETER IT



STRATEGIC DIAGRAM 7.iii

UNILATERAL IMPROVEMENT BY PF + SU FROM CURRENT SCENARIO  
AND SANCTIONS BY SOUTH AFRICA AND US + WEST TO DETER IT



If one takes the player PF + SU coalition, column (2) a unilateral improvement exists in the move to 'full support and a quick victory'. This however would be deterred by two sanctions (see Strategic diagram:7.iii). The first sanction would be SA moving to 'fully support' the Z-R player thereby 'Escalating' the war. This sanction is credible from the assessment. The other sanction is the US + West moving to 'full support' of the internal settlement, this would lead to a situation of full confrontation between US + West and SU which would turn Zimbabwe into a battleground. This sanction, in the wake of the Vietnam War and the mood of non-intervention in America, did not seem that credible. (It is interesting to note however that events during and towards the end of the year - Conservative victory in the UK elections and the invasion of Afghanistan by the Soviets - changed this attitude thereby making the sanction fairly credible!).

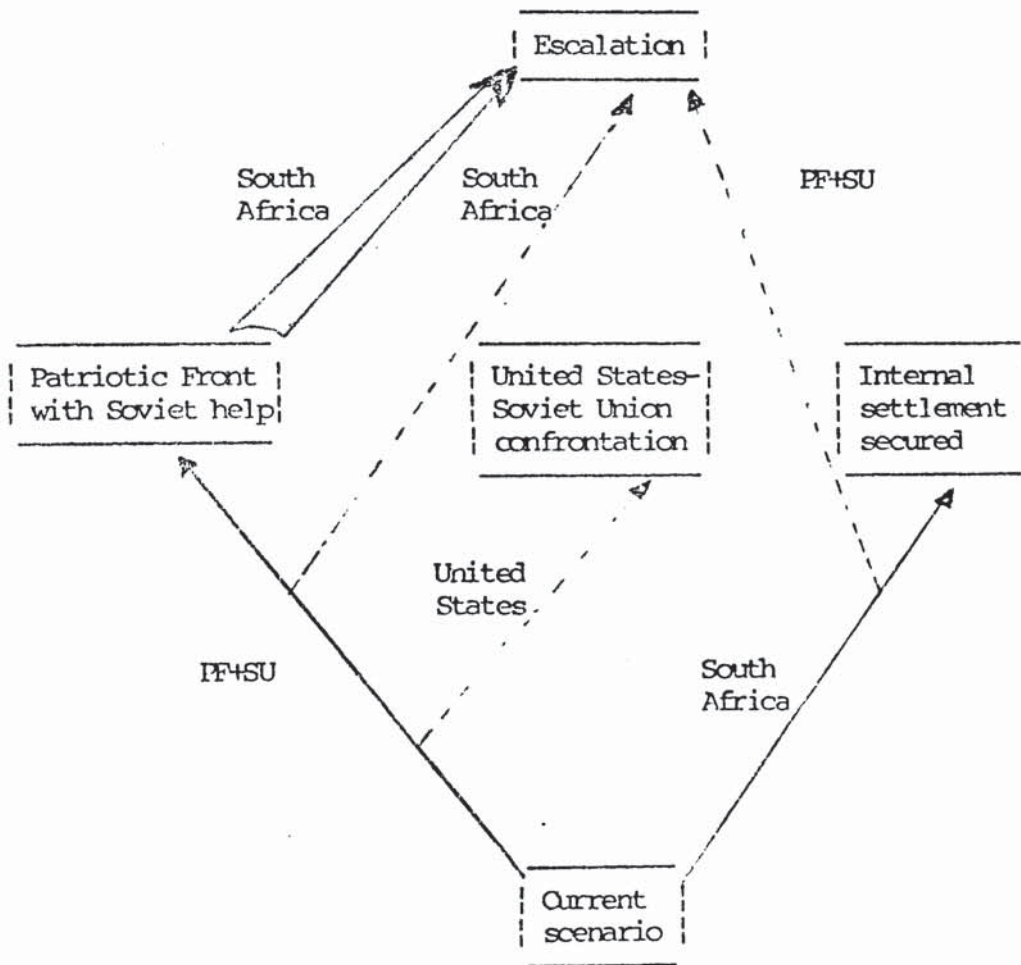
The analysis further considered (Tableau 7:1(i)) the assumption that PF victory with Soviet help be the particular scenario (P/S) - Column 3. Could this 'current scenario' be stable? In the SA view, a unilateral improvement exists for them if they move to 'full support' thereby 'Escalating' the war. They would rather have 'Escalation' than a PF victory. This was viewed to be a highly credible response - it is further a guaranteed or undeterrable improvement for them. Strategic diagram: 7.IV.



AT THE CENTRE OF EACH SECTION, THE 'PARTICULAR SCENARIO' (P/S) IS ENTERED. THE DIFFERENT PLAYERS' COALITIONS AND PREFERENCES ARE ANALYSED. THE SCENARIOS ASSUMED TO BE 'PREFERRED' TO THE P/S BY THE P/P ARE ENTERED TO THE LEFT, WHILE TO THE RIGHT ARE ENTERED THOSE SCENARIOS ASSUMED TO BE 'NOT PREFERRED'.						
		1	2	3	4	5
		P/S	P/S	P/S	P/S	P/S
WESTERN POLICY (US+WEST) (i) PASSIVE SUPPORT (ii) FULL SUPPORT (TO R-Z)		- 1 - - 0 0	1 1 - 0 0 1	- 1 - - 0 1	- 1 - 0 0 1	0 - 1 -
	SOUTH AFRICA (iii) FULL SUPPORT	1 0 -	0 0 1	1 0 -	- 1 -	- 0 -
	SOVIET UNION (iv) FULL SUPPORT	0 0 1	1 0 -	1 0 -	- 1 -	- 0 -
PATRIOTIC FRONT (v) FIGHT RHODESIA-ZIMBABWE (vi) FIGHT		- 1 - - 1 -	1 1 - - 1 -	- 1 - - 0 -	1 1 - - 1 -	- 1 - - 0 -
(vii) SUPPORT (viii) MARCHING SUPPORT (If 3 — 1)		- 1 - - 0 -	- 1 - - 1 -	- 1 - - 0 -	- 1 - - 0 -	- 0 - - 1 -
		SOUTH AFRICAN PREFERENCES	PF + SU PREFERENCES	SOUTH AFRICAN PREFERENCES	PF + SU PREFERENCES	SOME INFEASIBLES

STRATEGIC DIAGRAM 7.iv

UNILATERAL IMPROVEMENTS WITH SANCTIONS AND  
A GUARANTEED IMPROVEMENT FOR SA FROM PF VICTORY WITH SU HELP



If, as in Column (4), the current scenario is taken to be 'Internal Settlement secured' by SA giving 'full support' to Z-R, the PF + SU as P/P, have a unilateral improvement through the move to 'Escalation'. This was considered to be quite credible and actually preferred by the coalition to the P/S (current scenario) 'internal settlement secured'. The move itself is deterrable by the US + West coalition opting for 'full support' of the internal settlement; thereby moving to 'US + West' confrontation. Diagram 7.V. Whether this move was credible was doubtful (Assumption No.6, Schedule 7.b.) at the time of the analysis.

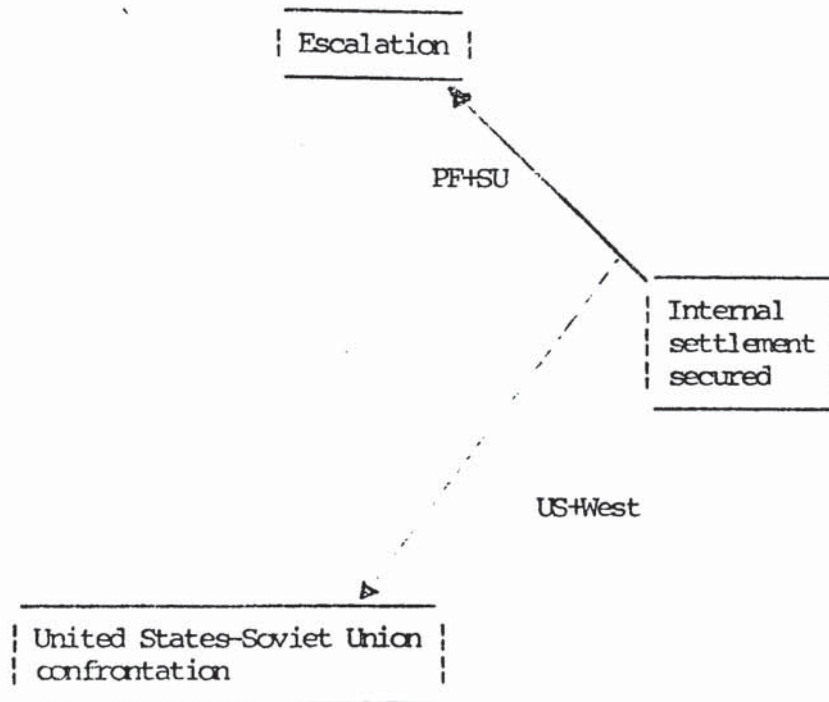
From the analysis shown in Columns 3 and 4, the stability of the 'current scenarios' considered in turn was questionable. For each of the unilateral improvements, there was no credible sanction; indeed, for column 3, the SA move is a guaranteed improvement! One can conclude that these situations were not stable for any of the players considered.

One player seemingly excluded from the analysis is China. As noted in Assumption 5 (Schedule 7.b), the Chinese, though important as backers of Zanu in the PF alliance, were not playing nor were they likely to play, a decisive role because of logistical problems. They would have a lot of difficulty 'matching-up' support as opposed to SA. In addition the nature of their foreign policy was such that they would put their relations



STRATEGIC DIAGRAM 7.v

UNILATERAL IMPROVEMENT FOR PF + SU WITH SANCTION



with the opposition before considering their 'clients' position. The SA did not consider them a serious threat.

In column 5 are shown some infeasible options. These are options which it would be incompatible, illogical or impracticable to consider to take - eg that the player US + West gives 'full support' without giving 'passive support'. It is still important however that they be noted and listed; it ensures that all combinations of options have been considered. This adds to the rigour of the method and technique.

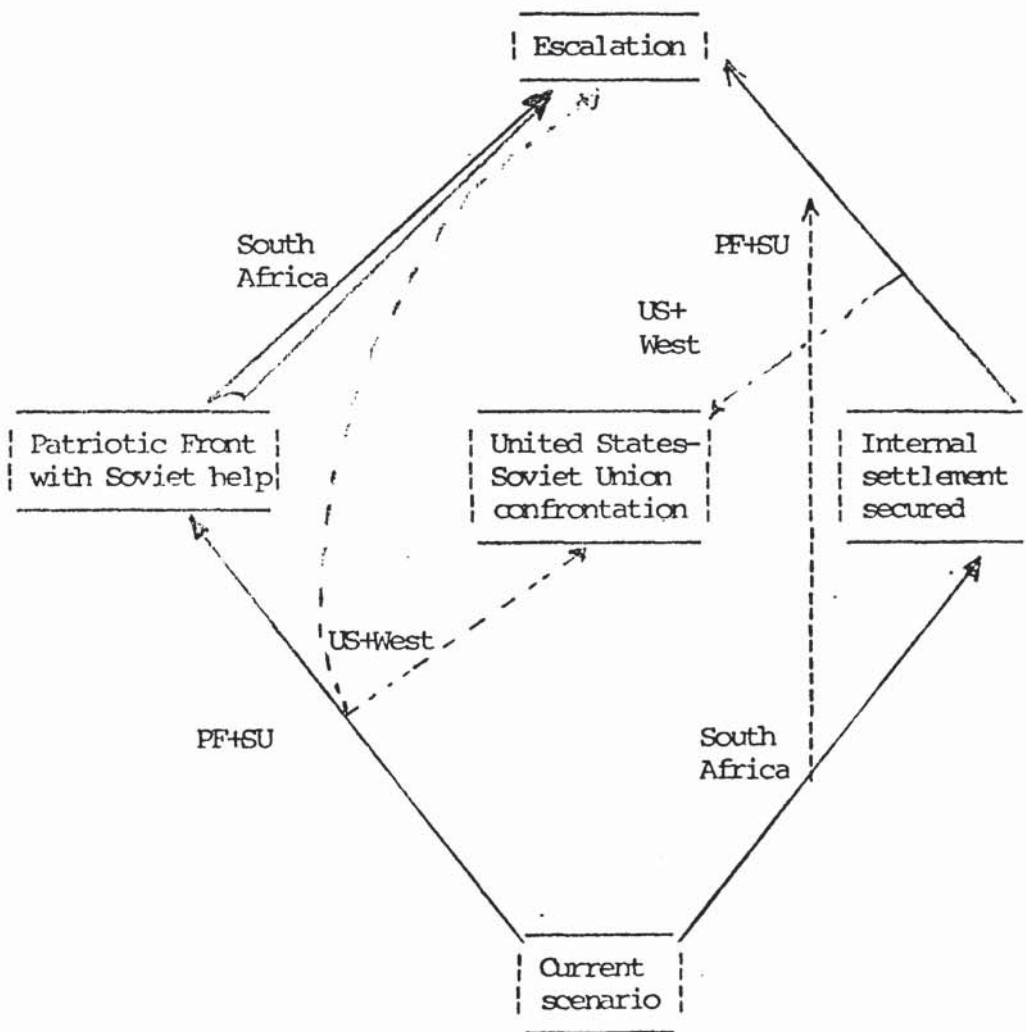
Figure 7(2) shows the model analysed and a number of possible scenarios.

The strategic diagram 7.vi depicts the complete model of the analysis progression. It (the analysis) has shown that the current scenario leading to a ZANU dominated PF alliance victory in two years is stable. This is the case as long as the players SA and SU continue to deter each other from giving 'full support' to their coalition partners. The fear by each of them that if they give 'full support' to their clients, the other will do the same leading to unpreferred 'Escalation', can be said to guarantee the stability of the current scenario.

Our analysis concentrated on the players locked in the

STRATEGIC DIAGRAM 7.vi

ANALYSIS OF COMPLETE MODEL SHOWING THE STABILITY OF THE CURRENT SCENARIO





bitter confrontation. An unforeseen change in the policy options of the other players could, depending on the 'strength' of their moves, however change the nature of the game and consequently the outcomes. This is what occurred when a 'Compromise Settlement' was reached but it does not invalidate the analysis.

#### INDEPENDENCE

The stability of a 'Compromise Settlement' was not analysed although it was considered as a possible scenario (Figure 7.2). It was the task force's view that this provided less problems and, given the then prevailing attitudes it was less likely as an outcome! As it turned out, it is attributable to changes in the options of US + West. This player, especially the UK member of that coalition had been 'dormant' throughout the struggle. The change came about as a result of the ascendancy of 'the hawks' to power in the UK and the US. This signified a change in the public opinion in these countries some of it arising from internal politics and some from the revulsion over what they saw as 'Soviet Expansionism' following upon the invasion of Afghanistan. The brutality of the war in Zimbabwe, the increased involvement of SA and the inevitability of a ZANU dominated PF alliance victory (wrongly attributed to Soviet involvement); combined with the aforementioned to pressure the US + West to do something.

FIGURE 7.2

SOME SCENARIOS IN THE COMPLETE MODEL

US + West: full support to Rhodesian regime	0	0	-	1	0	0	1
South Africa: full support to Rhodesian regime	0	0	1	-	0	1	-
Soviet Union: full support to Patriotic Front	0	1	0	0	0	1	1
Patriotic Front: fight	1	1	-	-	0	1	1
Rhodesian regime: fight	1	-	-	-	0	-	-

Current scenario	Internal settlement secured	Escalation
Patriotic Front victory with Soviet help	Compromise (e.g. 'fair elections')	United States- Soviet Union confrontation

NOTE: The dash ("-") stands for "1 or 0". Thus a column with several dashes in it represents a set of scenarios - all those obtainable by filling in the dashes with 1s and 0s. The titles in Figure 2 are thus given to sets of scenarios, which may differ from one another in certain respects, rather than always to unique scenarios.

Active and strong diplomatic pressure and manoeuvring, which saw the Commonwealth taking a strong position, won the day. This was crowned by the UK committing itself to holding a Constitutional Conference and to be followed by 'free and fair elections'. SA and Z-R had hoped that their internal settlement would be recognised by the US + West and would thereby attract their support through lifting of sanctions, etc. Instead the Lancaster House conference was held at which a racist Constitution granting 20% of the parliamentary seats to 4% of the population was signed. Despite strong protest from ZANU (PF) an election among the African population was held. With a 71% majority, ZANU (PF) emerged the unchallenged winner. This was despite lavish South African and Western backing for Muzorewa's UANC.

This victory demonstrated beyond doubt the popularity of ZANU (PF)'s strategy of articulating people's grievances, politicising them and then fighting with them. Every fighter was first and foremost a political cadre - herein were laid the eggs of future problems. The aims and objectives of the war could not be equally achieved by a multi-party democratic system because the former advocated radical transformation, whereas the later is based on gradual change and continuation of the existing institutions. The architects of the Lancaster House Agreement were well aware of the repercussions of electoral reform. Although taken by surprise at the victory of ZANU (PF) at the polls, they had built-in



safeguards which would ensure pursuance of a moderate course.

The speed with which the whole process of signing the agreement, return to legal status, ceasefire and assembling of the former guerilla forces, registration of candidates, campaigning, holding of elections, handover of power and withdrawal of the Governor, was carried out, contributed significantly to the crisis that already existed in the country. The ZANU (PF) led government was faced with serious problems of inexperience and lack of co-operation from a white dominated Civil Administration and business community. The provisions of the Constitution had entrenched clauses which protected the very institutions the struggle was prosecuted to overturn. Independence, in that regard, brought into sharper focus, internal political conflict which required to be analysed at the general policy level. There was a need to, at the same time that new measures were implemented, analyse the situation and formulate development plans accross the sectors. Assessment of all possible outcomes was imperative, but more urgently the need to move from confrontation to stable government was paramount.

AFTER INDEPENDENCE: THE RECONSTRUCTION CORPS

This analysis was done in May 1980. It is documented to demonstrate how Analysis of Options can be applied at strategic policy level to assist in the development of overall government policy. This is an essential first step because it lays down the internal political framework within which sectors or Ministries will proceed to detail their own policies. The outcome of this analysis was a Reconstruction Corps whose relevance to health will be examined in the next chapter. Once the concept was acceptable at the broad government policy level, it remained for the health care sector to develop programme specific ways of involving those cadres who had some training in the health field who fell under the broad definition of the corps.

Whereas sector specific problems vary, broad internal political problems determine the climate for sector planning. What then were the problems?

These can be listed as:

- (i) the ZANU and ZAPU guerillas who provided all the services and the administration to the rural areas under their control, remained confined to the Assembly points. This left the people without guidance, information and more relevantly health care. The effective

channel was therefore cut.

- (ii) the expectations of the masses who had fought alongside the guerillas and now voted them into power, were very high. The danger of revolt at non-fulfillment of these remained high. The consequences of revolt are invariably repression, loss of liberty and subsequent increase in poverty.
  
- (iii) the requirement for radical change which the party stood for and on the basis of which it won the elections, pressured for immediate action. This is difficult because to effect it requires new or radically changed institutions, mechanisms, personnel and resources. The new government inherited an existing system, an administration 'that had served the same government but different ministers for twenty years'.<sup>1</sup> The incumbent ministers found themselves having to preside over this establishment. Some ministries were even headed by men who had held posts in the previous regime.

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1. Dr H.S.M. Ushewokunze, M.P. Minister of Health for Zimbabwe, 1980 in a speech given at the Symposium, "Primary Health Care; Zimbabwe's Chosen Way". December 1980.



- (iv) The Lancaster House agreement, under which Independence was achieved, (a) required that the guerillas remain in the Assembly points and that they should be integrated with the previous Rhodesian army; (b) it made it difficult to remove or replace the established Civil Service. One of the entrenched clauses safeguarded those public servants whose job it is to translate government political objectives into action programmes. Ninety-five percent of the senior jobs in the Civil Service were held by the whites. For the new majority rule government to replace them was very difficult because this had to be approved by a Commission again dominated by whites. The conditions for appointment ranged from several years experience in the public service to very high academic qualifications. In both instances, ZANU cadres fared very badly. The few Zimbabweans who had managed to train overseas either lacked the political orientation or were not adequately experienced. The net effect was the retention of the old dragging ways of civil administration thereby putting the government in an embarrassing and potentially dangerous position of weakness to effect change.

The major challenge to the government was to avert the crisis of unfulfilled expectations of the masses which

would lead to political instability. Government priority became, of necessity, embarkation on reconstruction programmes in the rural areas where eighty percent of the black population lives. The old links could then be re-established and the administration would be forced, from below, to action programmes that benefit the majority.

The new power centres, which constitute the players in this game, are shown in Schedule 7.c. As in the previous game, South Africa, the Soviet Union, the United States and the West; remain ready to take economic or military measures to further their objectives. Their choice of these options is however now limited by the legitimacy of the government. To that extent, their positions and the power they wield have changed greatly.

ZANU (PF), ZAPU and the white officers of the former Rhodesian Army, now constitute the critical forces. If the guerillas remain in the Assembly Points doing nothing - discontent and demands for a key role in the new order, would spark a new conflict. Since the concept of their integration into a single army was accepted by the Prime Minister, who is also the Minister of Defence, this should be taken advantage of in the form of a Reconstruction Corps.

The corps would be charged with the task of working with the rural people on any projects they considered a

priority, ranging from harvesting, housing construction, infrastructural construction, schools and clinics repair to the provision of health care itself through prevention work like spraying and actually curing patients at clinics and in rural hospitals. Ideally, it was to be made of politically conscious cadres in the army, who would explain government intentions and listen to the people's grievancies and then feed back to the top. Integration however meant that some dilution of their political role was inevitable.

Integration was to take a long time, but given the large number of men under arms, they could be a huge manpower source for reconstruction projects.

Developmental projects could later be started at the completion of reconstruction, in which skills gained would be of a tremendous value. The potential for a corps was therefore quite significant.

A slight dilemma existed for a reconstruction corps even before one analyses its stability. The guerillas who will constitute it, had politicised the masses and organised them along the lines of self-rule (at local level). ZANU (PF) stood for that and indeed had won the elections. Could it then effect it now that it is in power? How consistent would the reconstruction corps concept be with the requirement to honour the Constitution? How would the guerillas now integrated in the army and working in the reconstruction corps now



present themselves to the masses? What is their likely reaction to Administrative policy carried out by the old structures which go against the principles they taught the people?

There are some noticeable advantages in the corps. The guerillas would at least be back among the masses which in itself would be reassuring. Through channels other than the old administration structures, they will make information available to government on the progress or otherwise of the programmers. More importantly they will inform on the reaction of the masses on the government's initiatives or lack of it. This information would be invaluable in the government's fight to change the content of the Civil Service.

Whereas party state rule has structures which enable the undiluted flow of the masses grievances to the top; democratic government structures set up under the Lancaster Agreement, entrenched a Civil Administrative structure that was to be independent of political control. Its bureaucratic machinery could not surely be expected to pass on to government information about its own inadequacies. In addition, the pace of bureaucratic functioning, is such that by the time the government chiefs hear of the grievancies the people would be exasperated, thereby damaging the party image.

The analysis was aimed at determining the stability of a Reconstruction Corps as an option available to the

government or more precisely, the Prime Minister.

In Figure 7.3 I show the players, options and some scenarios.

The threat of SA continues to be real. The reasons for this are many besides that it is afraid of a black socialist regime as a neighbour to whom it lost the fight. This is an important observation for planning purposes because the level of stability achievable is dependent on the extent of the South Africa interference, influence and the timing of it.

As shown in Tableau 7.1(ii) the ZANU government has a unilateral improvement in setting up a ZANU only reconstruction corps. This move would perhaps be deterrable by three kinds of sanctions:

1. the white officers would resign, followed by a mass exodus of whites which would damage the economy,
2. the white officers may join with ZAPU guerillas and attempt a coup with SA help or,
3. SA may intervene with or without invitation. This would lead to a resumption of the war but this time ZANU would be in a stronger position because as a legitimate government, it may

FIGURE 7.3

PLAYERS, OPTIONS AND SOME SCENARIOS  
IN THE PROBLEM OF FORMING A RECONSTRUCTION CORPS

ZANU Government (Defence Minister): form reconstruction corps	0	1	1	1	-	1	-
White officers (General Walls): demand balanced corps	0	0	1	1	-	-	-
resign	0	0	0	0	-	1	-
attempt coup with ZAPU	0	0	0	0	1	0	-
call in South Africa	0	0	0	0	-	-	-
ZAPU Leadership: demand balanced corps	0	0	1	0	-	-	-
attempt coup with Whites	0	0	0	0	1	0	-
South Africa: intervene	0	0	0	0	0	0	1

↑	↑	↑	↑	↑	↑	↑	↑
Current scenario			ZANU- White corps		White exodus		
ZANU-only corps	Balanced corps	Coup attempt					
					South African intervention (with or without internal support)		



TABLEAU 7.1(ii)

PREFERENCE ASSUMPTIONS FOR ANALYSIS OF  
THE POLITICAL FEASIBILITY OF FORMING A RECONSTRUCTION CORPS

	(a)	(b)	(c)
	<div>—        </div>	<div>—        </div>	<div>—        </div>
ZANU Government: form reconstruction corps	1 ← 0 - - - -	1 1	1 1
White Officers: demand balanced corps	- 0 - - - -	1 ← 0	1 1
resign	0 0 1 - - -	0 0	0 0
attempt coup (with ZAPU)	0 0 0 0 1 -	0 0	0 0
call in South Africa			
ZAPU Leadership: demand balanced corps	- 0 - - - -	0 0	1 ← 0
attempt coup (with Whites)	- 0 - 1 - -	0 0	0 0
South Africa: intervene	0 0 0 0 0 1	0 0	0 0
	<div>—        </div>	<div>—        </div>	<div>—        </div>
	ZANU Government preferences (?)	White officer preferences	ZAPU preferences

call on anybody for help against external aggression.

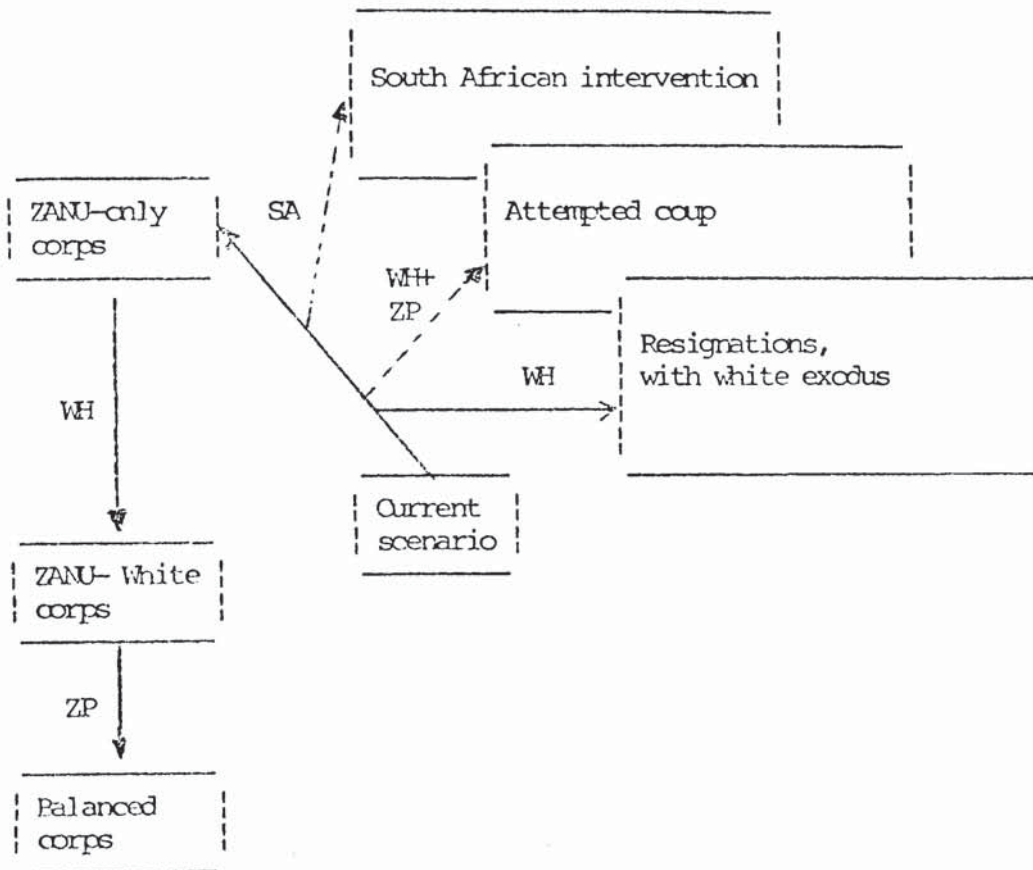
The analysis conclusions were that though the prospects were serious, it was questionable whether they are actually sanctions. ZANU might prefer these prospects with a strongly placed guerilla army reconstruction corps to the current scenario without one.

If we take the formation of the reconstruction corps as the 'current scenario' (Column 'b' Tableau 7.1(ii)), the white officers may have a unilateral improvement to their position by joining it. This would give the corps some balance. Given that position, ZAPU would not want to be left on its own. It would also prefer to join (Column 'c'). In the Strategic Diagram 7.vii, I show the composite moves.

The formation of the reconstruction corps was a feasible move. Neither of the threats which might have deterred it were sufficiently feasible to deter it. These threats might have led the players into scenarios they themselves did not prefer. With the move to an official policy of reconciliation, the Prime Minister made the options of non-cooperation even less feasible.

STRATEGIC DIAGRAM 7.vii

ANALYSIS OF THE FORMATION OF A RECONSTRUCTION CORPS





## ADVANTAGES AND DISADVANTAGES OF THE ANALYSIS OF OPTIONS

In this chapter, I covered two analyses specific to Zimbabwe's experience at the international and broad government policy level. In the next chapter I intend to consider more uses of the technique in the planning and management process, specifically in the health care sector. Before proceeding to that however, a summary of the general advantages and disadvantages of the technique is made. In the process mention is made of our experience to emphasise any relevant points. It is hoped that in the last chapter on Conclusions, some general statements on the feasibility of general dissemination of the method will be made. Reference will of course be made to points made in this section.

Political situations like complex decision problems, tend to be fuzzy and unclear. They are characterised by conflict or confrontation. Often, the number of players and their options or courses of action available to them are unknown to the participants. In such situations, there is no one single player who can influence the decision or outcome on his own. A multiplicity of games are going on all the time at varying levels and in hundreds of inter relationships. The Analysis of Options technique progression helps to identify which participants are being considered and for what options or choices of courses of action.

The main benefit is in the orderly arrangement and display of possible future scenarios and in the introduction of the estimated preferences of the participants for those scenarios into a structured analysis.<sup>1</sup>

The technique, which is based on the theory of games and metagames, is soundly scientific and systematic. Despite this seemingly complicated origin, its procedure is readily understood by those without any specialised knowledge of it. It can be applied with the minimum of guidance from highly trained analytical personnel. It is a method of analysis which responsible managers and decision makers seem to adopt naturally, probably because it parallels in many respects procedures that they arrive at intuitively as a result of experience.

It allows the decision makers (politicians, managers, and community heads) to view their own behaviour and notice the effect of knowing one's pay-offs. Because the technique does not prescribe a solution to the decision-maker, but merely explains, analyses and predicts stability; the decision maker has to decide for himself which course of action is most suitable for him to get out of the predicament he faces. This goes a long way towards ensuring that players or decision-

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1. Radford, K.J. (1977) p.91.

makers, do not dissociate themselves from decisions they made or participated in making. It makes it imperative for them to see their decisions through. Its use allows policy makers to take an active part in the analysis phase of the process of resolution, rather than delegating major parts of it to specialists who do not bear the responsibility for the final decision. It is a most effective way of extracting a commitment from policy makers to support a course of action assumed to bring about a desired outcome. The construction of tableaus attempts to ensure that no combination of anticipated actions by the participants is overlooked. Identification of infeasibles in a similar manner acts as a double check.

One of the distinctive features of the technique of Analysis of Options is the fact that the players can only get out of the game as much as they put into it. This forces the policy makers to think over their situation and make adequate preparations which may mean a change in behavioural patterns which would include openness in a group situation. Through the discussion phase they are forced to defend whatever proposition they make. The process of reflecting on propositions and drawing own conclusions with regard to present scenarios and what are considered the probable outcomes, enables the participants to build a picture of their situation. This process helps establish preference relations of the participants



over a set of outcomes. Since preferences are dependent on current outcomes, these have to be viewed by the players. In our experience, because the analyst continued to ask searching questions about aspects related to the problem under discussion, this helped us to concentrate our discussion on the decision problem; while at the same time ensuring that the discussion remained broad enough not to exclude aspects which could turn out to be relevant. This may not be that easy to do in a situation where the analyst is a junior officer and the participants are senior officials not used to being asked searching questions. In some instances participation in the group situation may be so low that substantive material for analysis may not be forthcoming. Most high level decision problems may not be ideal for open group discussion and conversely high level decision makers may not be well disposed to having their problems discussed in an open group situation. The analyst will have to try and break the ice somehow.

Through identifying the players and options open to them, and working directly with them, the analyst applies the theory to a situation. He has to satisfy the requirement that the players 'fully understand', this interaction by working directly with them and by obtaining their subjective view of the situation. It is contended that 'the one and only view of the situation that they do understand, is their own subjective view. The subjective game is the unique

game to them<sup>1</sup> - the one they fully understand. Any objective view that differs from it is not to be used in the application of this theory. The technique therefore recognises that values and attitudes play an important role in the interaction that occurs in a decision situation because of their influence on the behaviour of the players.

The use of metagame in conflict situations, enables decision makers to be made to understand that the existence of conflict, (which is inevitable in 'political' situations and complex decision problems) is not as such a bad thing because it promotes co-operation by giving rise to the need for it.

(Radford (1977) p.75). It is a means of getting some unity; and integrative rather than destructive force.<sup>2</sup>

It rejects the idea of a 'best' course of action in a political conflict because no single player controls the course of his actions. The inherent need for a process of negotiation through interaction of the participants which necessitates their varying their preferences for courses of action and future scenarios in response to the actions and reactions of other

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1. Howard, N. (1972) "The Arab-Israeli Conflict: A Metagame Analysis". Done in 1970. (Introduction Notes and Discussion added, p.6.)
  2. Simmel, G. (1955) "Conflict and the Webb of Group Affiliations". Free Press of Glencoe, p. 13-20.

players; means that they proceed along an unpreferred alternative. It remains however recognisable that the process of bargaining and negotiation, holding-out and giving-in, which follows the analysis; improves the nature of the decision taken. In addition sensitivity testing which follows the analysis, improves the quality of decisions by including factors which might have been deliberately excluded or underplayed and changes in circumstances affecting the possible outcome under consideration.

The very political nature of the Zimbabwean situation rendered itself ideal for the application of this technique. The dynamic nature of the situation and the extent and depth of the crisis, all required a method of analysis capable of breaking up into a variety of other games and at the end of the day pulling them all together and synthesising these into a definable and stable outcome on policy outline.

Our analysis of the Zimbabwean conflict disclosed one of the main weaknesses of Metagame. Because of the need to avoid creating a situation of 'conflict within conflict', only those decision makers from the same party were included in the task force. This limits the extent to which other players' options, actions and reactions are assessable. Nevertheless, since our main concern is with clarification, analysis and structuring of a conflict situation as 'the player sees'



it; this does not adversely affect its rigour. Under the game, the quest for stability and hence some element of predictability, means that a player is willing to commit himself for the future in exchange for commitments by others. The technique is non-quantitative although it is fully rooted in mathematical theory. This non-use of numbers has made it the subject of debate. Its proponents have abandoned, "the attempt to quantify phenomena that are qualitative by nature". (Howard, N. (1972) p.68).

In the absence of people in the actual decision making process or involved in the actual conflict, assumptions as to their options, actions and reactions (from a knowledgeable basis) have to be made. Admittedly these may be less accurate. The point however remains, that the exercise itself enables one to view the problem differently. It constitutes the first step in the solution process.

In the following chapter, I view the extent to which the game was used in setting out and execution of the health care sector plans.

PART IV

This is the final part of this study. It is made up of Chapter VIII, which examines, 'Planning and Management for Health for Development'. This starts by examining health and development, concluding that indeed the former may provide an 'entry-point' to development. Through a brief assessment of inter-sectoral programmes undertaken in the field, the place of health as concern for all sectors if people in countries are to develop is highlighted. Because these programmes are community based, need-oriented and require a real attitudinal change, planning for them has to take a different form. The conventional forms of planning for health care are challenged and new approaches proposed. These require the use of supportive techniques since they lay considerable emphasis on the role of political factors. The application of the analysis of options during the transition period is viewed through actual experiences in the areas of: the central level political gaming and reorganisation, the question of resources and their distribution \_ drug supply issues, and the manpower experience through the integration of the ex-military medics. Finally, the nature of the P.H.C. approach adopted in the country is viewed.

In Chapter IX, concluding comments and remarks are made which are intended to summarise the study contribution and what areas may be of interest for further research.

PLANNING AND MANAGEMENT OF HEALTH FOR DEVELOPMENT IN ZIMBABWE

"The non rational, 'political' nature of social decision making should be seen not only as inevitable, but also as desirable."

Radford, K.J. (1977).

'Complete decision problems: An integrated strategy for resolution', Reston Publishing Coy. Inc., pp.X

"Value systems are essentially patterns of belief that govern behavior in choosing between alternatives. Values are the basis of the identification of needs and of the response to needs by individuals and groups. They are also significant factors in setting standards of expectation and in judging the appropriateness of methods of achieving these expectations".

(Radford,K.J. 1977, pp.22).



(i) INTRODUCTION

The preceeding discussion has shown the extent of the complexity of the problems facing Zimbabwe. It has also shown that, before viewing sectoral problems, it is essential to situate them in a crystallised framework. The analysis of options technique can help decision makers do that. The advantages of using it in complex situations that occur at the policy level were outlined. It is the intention in this chapter to review the attempts made in the field to relate health and development through careful design of actual programmes, using the technique. Since it is the intention to advocate its increased usage in sector planning, an assessment is made of hitherto approaches used in the health care sector. It is argued that these old modes of planning overlook important considerations which ought to be included, hence the scope for positive change exists. a look is taken at the applications of the technique during the post independence period in the development and implementation of health care policies. To complete the picture, the net outcome of the efforts, in the form of the approach finally adopted is viewed.

(ii) HEALTH AND DEVELOPMENT: FIELD EXPERIENCES.

The discussion in chapter two highlights the fact that development is both a process and a condition. It means more than mere economic growth, in order to be authentic, it must be complete and intergral. The human and the economic elements in it are integrated as the best way to ensure growth to fullness. Under this conception, emphasis is put on its human side as shown by the definition that it is 'the growth to fullness that is humanity'. It is the human advancement aspect of development which is emphasised.

This is in conformity with the observation that development's economic and non-economic elements interact organically. Hence, 'it has often been viewed as a multi-variable \_ quantitative and qualitative change, which may not be measurable cardinally and requires the use of value judgement'. (See Chapter II). Whereas a lot has been written about the quantitative aspects of development or lack of it, very little has been said on the qualitative changes that occur. Often, this is because of the difficulties of assessing them. This might have arisen because of the need to bring both growth and social justice together in programmes of action. Such a move brings development into an all-comprehensive sociological problem which must of necessity address itself to power relations within society. As a consequence, conflict resolution has to be built into any developmental decision making process.

Development is a long-term proposition, its impetus is maintained by policies that must be both directed at fundamental change and

viability in the short-term. So too is health as broadly defined. Underdeveloped countries are doing today what they should have done yester-year and that too, at a slow pace for those who have taken the bold decision to direct their efforts towards health improvement. There has also been the tendency to discuss development only in terms of policies, without regard to the institutions and people who decide and execute them. This imbalance has led to continued resource maldistribution and poor management. As a consequence, the poor have remained poor if not dragged further into poverty with the consequent adverse effects on health. The vicious circle continues unbroken and at a faster pace. It therefore behoves the government to balance its plans at the centre, through the development of efficient and effective mechanisms to ensure that its sectors complement towards the attainment of set and unambiguous objectives. By its nature, it is argued that health provides a viable 'entry-point' to this overall effort.

Hitherto, planning has been excessively concerned with producing detailed, long term blue-prints for development, to the exclusion and neglect of policy analysis. The process of planning, which is considerably more important than the plan produced, has remained a closed affair, known only to the inner circle of economists when the plans produced, are infact intended for the whole population. The people are alienated from its preparation and yet they are not only expected to work within it but also to live within the limitations it sets. The new direction must centre on 'opening up' this process, so that there is wider participation, more importantly, there must be wider involvement of those 'hangered' on to the bottom of the ladder,



who constitute the majority. Since they are the ones who suffer most from infectious and communicable diseases, malnutrition and debility associated with poverty, they must be involved so they understand their plight and do something about it. To do so is to enable them to share in the exercise of political power which tends to be confined to a few people at the top. It is a form of equalisation which gives both health and development a tremendous boost, but nothing near the gains the involved communities obtain.

The government can attain the above through decentralisation. This will be dealt with in the next section, but suffice here to observe that it is a way of increasing the responsiveness of government to those it serves. It should involve those outside government whose active support is often necessary to promote development. The key factor here remains the need for political commitment by the leadership, to improve the conditions of the people, through encouraging and supporting active involvement and participation in the development process.

The poor performance of the underdeveloped countries is not however solely the fault of these countries. The discussion in chapter two demonstrated how dependent these economies are on the developed countries. Because of the existing unequal exchange (which has worsened with the depression) the underdeveloped countries have had to produce more for less and in the attempt to better their returns, through reducing production costs, they have had to pay less wages and employ less people thereby restricting employment in the face of already unprecedented unemployment. The hardships that follow these

economic policies are very damaging. A high level of self-sufficiency would have reduced the adverse impacts of the international markets dependence through reduced imports.

As observed earlier, weak institutions and management have contributed much to the plight of the underdeveloped countries. To improve this requires the expansion of education and training. This must however be appropriate education for the countries if the scourge of the brain-drain to developed countries is to be brought under control. Improvements in literacy levels have been invariably accompanied by better hygienic and feeding practices, better sanitation and clean water utilisation which reduces disease incidence. Investment into long term social improvement, which is invariably coupled with economic gains, should override demands for immediate economic gains through investment in the restrictively defined productive sectors. This is a political process that in itself requires careful management.

The governments seeking change have to start by addressing existing institutions that have their own historical inertia and underlying political interests. To get to where they want, involves negotiation and compromise \_ a complex process, difficult to manage without the necessary expertise. The temptation to tackle all the issues at once is strong but often perilous, hence the proposition to use health, as broadly defined, as an 'entry-point' and the health care sector as a focal point. This is not to rule out intersectoral action and coordination in other activities but merely to recognise the difficulties that exist. Once the opportune time is lost, it would be

a long while before an opportunity offers itself and often people will be changing then and so will views.

#### EXPERIENCES:

In the case of Zimbabwe, nutrition, a key component of health (and also a department I headed), offered an opportunity to set-up programmes of an intersectoral nature. The department is in the Ministry of health headed by a director who is accountable in turn to a deputy-secretary and ultimately to the secretary for health. A number of other ministries also perform a variety of nutrition and nutrition related activities. The inter-ministerial programme development was based on the recognition that no one sector can conceivably and adequately tackle all the issues in nutrition. Besides, following upon the war, there was an imperative need to pool and co-ordinate the various efforts of sectors at providing for the at-risk-groups, especially children under five. The field experiences of 1980 through to 1982, demonstrated how much can be achieved and what problems are likely to be encountered. Two programmes are briefly viewed to show the interacting factors. These are the children's Supplementary Feeding Programme and the Supplementary Food Production Programme.

The Children's Supplementary Feeding Programme (CSFP) was started by non-government organisations in 1980 following the attainment of independence. It was aimed at providing a supplementary meal to those children under five years of age who were mildly or moderately undernourished. The NGO's started the programme after recognising (through their institutions and voluntary care services) that the



health condition of returning refugees and displaced persons, especially the nutritional status of children under five years old, was very bad. Using anthropometric measures weight for age, weight for height, height for age and mid-upper arm circumference \_ they screened the undernourished and registered them for supplementary feeding. This was to be once a day in-between meals. The supplement was made of locally grown maize, groundnuts and beans, with oil and salt added on. The children were organised into feeding points of 10 to 40 children each and their mothers took turns to prepare the meal after instructions. The feeding points are located within villages.

The government's awareness of the seriousness of the problem arose after I led a UNICEF sponsored Ministry of Health national nutritional survey in 1980. This showed the problem of undernutrition to be widespread with 40-60% of the children under five affected up to 15% of them severely. The NGO's could not cover the whole country, so they handed over the programme in 1981 to the Department of Nutrition in the Ministry of Health. SIDA agreed to continue to fund the programme until the next harvest. It was clear to me, as head of the department, that for the programme to run more efficiently and effectively, other relevant Ministries had to be systematically involved. Discussions to this effect were started with individual Ministries and agencies. The result was the Inter-Ministerial National Co-ordinating Committee for the CSFP. The Schedule 8.1 shows the ministries and agencies involved and their different roles.

Each sector and agency had a contribution to make, without which it would have been difficult to run the programme. The community's

response was critical once they had explained to them what the programme was intended to do. Their involvement was in respect to selecting a group leader, preparing the meal and collection of the food packs wherever they are stored. The involvement of other extension officers-community development officers, health staff, Local government promoters, social service officers, teachers and agricultural extension officers, was mainly supervisory. Although the programme was initially intended to run until the end of the harvest, the persistent drought has meant that it has continued to run.

The Supplementary Food Production Programme (SFPP) was the logical follow-up to the CSFP. Although initiated under SIDA funding, it was expected to be self sustaining and to generate its own momentum after the first year. It was intended to enable, as a starter, communities to provide their own food to feed the undernourished children in their areas. The plots were to be used for demonstration and provided a rallying point.

Each of the sectors shown in Schedule 8.2 had a specific role to play which contributed to the nutritional requirements of the underprivileged children in the local communities. The village communities were willing to provide a plot, schools volunteered to release children to clear the plot, weed and harvest, as part of education with production. The men in the villages, who would usually regard this as a women's activity, ploughed the plots for planting and assisted in applying the fertilizers, under the guidance of the agricultural extension officer as part of modern farming methods training.

SCHEDULE 8.1

CHILDREN'S SUPPLEMENTARY FUNDING PROGRAMME

MINISTRY	INTER-SECTORAL ACTIVITY FOR WHICH RESPONSIBLE
1. COMMUNITY DEVELOPMENT AND WOMEN'S AFFAIRS.	PROVIDE COMMUNITY DEVELOPMENT OFFICERS WHO ORDER AND STORE THE FOOD. DEMONSTRATE HOW TO PREPARE IT AND SUPERVISE THE MOTHERS ESTABLISH FEEDING POINTS AND KEEP REGISTERS WEIGH CHILDREN.
2. LOCAL GOVERNMENT AND TOWN PLANNING.	THROUGH THEIR DISTRICT ADMINISTRATORS AND THE DISTRICT DEVELOPMENT FUND PROVIDE TRANSPORTATION OF FOOD ITEMS TO DISTRICT CENTRES AND FROM THERE TO OUTLYING AREAS
3. EDUCATION	TEACHERS STORE FOOD ITEMS IN SCHOOLS AND KEEP REGISTER OF CHILDREN BEING FED.
4. AGRICULTURE	THE GRAIN MARKETING BOARD SELLS BEAN AND GROUNDNUT ON PRIORITY BASIS TO THE PROGRAMME EXTERNAL PROCUREMENT WHEN INTERNAL SUPPLY IS INADEQUATE.
5. NON-GOVERNMENTAL ORGANISATIONS	FUNDING AND SUPERVISION OF THE PROGRAMME
6. SWEDISH INTERNATIONAL DEVELOPMENT AGENCY.	MAIN PROGRAMME FUNDER.
7. LABOUR AND SOCIAL SERVICES	PROVISION OF FOOD UNDER THE DROUGHT RELIEF PROGRAMME.
8. FINANCE ECONOMIC PLANNING AND DEVELOPMENT	PROGRAMME APPROVAL.
9. PRIVATE SECTOR	SELL FOOD ITEMS AND PACKAGING.
10. HEALTH	OVERSEE OVERALL IMPLEMENTATION, FUNDS PROCUREMENT AND PROGRAMME EVALUATION.



SCHEDULE 8.2

SUPPLEMENTARY FOOD PRODUCTION PROGRAMME

MINISTRY	INTERSECTORAL ACTIVITY FOR WHICH RESPONSIBLE.
1. COMMUNITY DEVELOPMENT AND WOMEN'S AFFAIRS.	DEVELOPMENT OFFICERS ORGANISE MOTHERS TO REQUEST COMMUNITY PLOT TO GROW GROUNDNUT OR BEANS DISTRIBUTE SEED AND FERTILISER TO PLOTS, ENSURE TIMELY PLANTING, REAPING AND STORAGE OF CROP, INSTRUCT ON PREPARATION.
2. LOCAL GOVERNMENT AND TOWN PLANNING.	TRANSPORTATION OF SEED AND FERTILIZERS PROVISION OF COMMUNITY PLOT.
3. EDUCATION	PLOT CLEARANCE BY SCHOOL CHILDREN, PLOT WEEDING AS PART OF EDUCATION WITH PRODUCTION.
4. AGRICULTURE	EXTENSION OFFICERS INSTRUCT ON PLANTING AND USE OF FERTILIZERS IN CROPPING, SEED. PROVISION
5. NON-GOVERNMENTAL ORGANISATIONS>	PROGRAMME INITIAL FUNDING AND SUPPORT.
6. S.I.D.A.	MAIN PROGRAMME FUNDER.
7. FINANCE ECONOMIC AND DEVELOPMENT	PROGRAMME APPROVAL.
8. PRIVATE SECTOR	SELL FERTILIZER.
9. HEALTH	DESIGN PROGRAMME, SECURE FUNDING, PROCURE SEED AND FERTILISER, DRAW GUIDELINES ON USE.

The health imperatives of an at-risk-group sparked a chain of activities which are health related but clearly developmental. The spillover effects in terms of community organisation, self-sufficiency, increased knowledge and inter-disciplinary joint-working, will do more to benefit the population than any one of the sectors alone could have achieved. From a planning point of view, the effect of any particular policy measure depends on all other policy measures and is by itself indeterminate. If one were to view it from a cost-benefit point, the benefit derivable from the combined contributions of the groups noted above are higher than returns each of the cost centres would have obtained individually. For no extra staff costs, the Ministry of Health for example is obtaining increased contributions to health from both frontline staff and national level personnel.

Attempts at establishing co-ordinating bodies have a bad track record in many countries essentially because of the level at which these are established (1). All too often, top level 'co-ordination is merely part of the pathology of overcentralisation. Decisions are referred up the hierarchy, and ministers are absurdly overstretched 'co-ordinating' everything in their portfolios or negotiating over details with their cabinet colleagues (Ecuador was quoted as having almost 200 co-ordinating boards, committees and commissions 1). In the end coordination can degenerate into mere 'bureau-shuffling'.

1. Among these are countries in the Middle-East, South America, Africa and the United Kingdom as quoted in The World Development Report 1983 pp.119.

The failure of planning is often seen as partly a consequence of expecting planning agencies to act as co-ordinating 'overlords' of economic policy even though crucial information, political influence and operational responsibilities remained with ministries that had nothing to gain but much to lose from cooperation. Such a coordinating role is possible only if planning agencies influence budgetary allocation. Despite these limitations governments continue to set-up these bodies \_ is it because they feel something is wrong in their structures and decisions which they are either unwilling to correct or powerless to do so? Either way, the net effect is simply postponing improvements of their cabinet decision-making or top level policy analysis.

Political support for human development cannot be taken for granted. The poor frequently are politically weak. They are often too sick, uneducated, geographically dispersed and busy to be politically active. Influential elites, particularly large land-owners, may oppose human development programmes if they feel that their power and status might be undermined. Whereas all this is true, health by its nature, tends to court sympathy. If the right expertise and heart is there health based programmes can spark-off real human development programmes that bring about redistribution of wealth and power without inviting the wrath of the already dominant groups. If co-ordinative mechanisms are instituted at executing levels, through often 'informal' linkages and spearheaded by informed operatives, they do yield long-standing benefits towards development.



(ii) HEALTH CARE SECTOR PLANNING REVISITED: SCOPE FOR POSITIVE CHANGE?

The current dilemmas in some developed countries in health care (e.g. U.K) revolve around the concern to close the present supposedly too many hospitals facilities, in order to improve efficiency and better use of resources, from the manager's view point. The patients and health workers argue that this leads to increased hardship for the former \_ through early discharges to make room for new cases, and more workload and poor care due to reduced facilities, for the latter. The economic proponents argument is said to be based on their perceived socialisation of medicine. (The NHS is said to be the product of the socialists). This is a form of the powerful and influential group's challenge to the advocates of the increased provision of health care, at little to no charge, to enable the poor to have better access and thereby improve the nation's health status. Even under the NHS, the powerful consultants and specialists had their power and status increased. The architect of NHS, Aneurin Bevan, is quoted as having feeled the consultants 'mouths with gold' to get them to agree with it (1). By providing them with the freedom to function without interference from the secular organisations, Bevan, robbed the public from having a say in the type of care they received. In the end, it is concluded that, "...the NHS was shaped by the status quo, reflecting the wishes of the powerful." (2). This is the case with almost all health care sectors adopted at independence and continued thereafter.

1. The Politics of Health Group: "Cuts and the NHS", Pamphlet Two, London.

2. Ibid pp.9.

The legislation that instituted health care systems in countries was drafted by governments and continue to be drafted by governments who it would be erroneous to consider, as acting with the best of intentions and with a free hand to create new social institutions without changing wider social arrangements. The conventional modes of health care planning therefore reflected the dominant power groups' preferences and thinking which in most developing countries were initially foreign, but were later replaced by a co-opted indigenous elite.

The justification provided by the architects of the above style of policies almost always ends up as being, the need for economic stringency in the face of the depression. Evidence still exists that the conventional view of economic growth as an unmixed blessing for human health and well-being continues to be accepted especially by national and international policy-makers. There is therefore a need to redefine development not as economic growth but as something considerably more. Alas, the notion that greater consumption brings greatest good, has been abandoned on realisation that obesity, death from degenerative and heart diseases, a result of overconsumption of super refined foods, are just as bad as undernutrition and death from Kwashiorkor and marasmus a result of underconsumption. So it is that the outcomes of unbridled economic growth without fuller human development are equally as bad as the products of underdevelopment. Human development has therefore to be seen in its fuller context in both developed and underdeveloped countries.

In the developed, as in the underdeveloped countries, the entrenched power groups have resisted change for the better for the whole population because it threatens their interests. In the final analysis, the majority of the populations in both countries suffer an unacceptable level of ill-health in the face of such abundance. The attempt to maximise economic activity and material growth is symptomatic of the conception of progress that underlies conventional economic thinking. The consequence has been that planning in all sectors, including in health care, has had to be subservient to it. In choosing consciously or by default, to pursue economic goals, industrial societies (or for that matter developing economies), may be sacrificing the opportunity to pursue rational and humane health goals. To pursue human development therefore, planners of national economies must recognise that 'wealth producing' cannot be unthinkingly equated with 'well-being producing', and that health goals require explicit consideration in their own right. The tendency however to view well-being as a state, ought to also be abandoned in favour of the more realistic appreciation of health as the dynamic process of interaction with the environment. This permits the introduction of interventions of a planning nature intended to restore or maintain the balance of interaction.

The conventional modes of planning should not be discarded as outmoded without learning from them. They concerned themselves with maximising the use of resources and identifying the optimum solution. Minimum cost and maximum benefit was the guide. It is their over-indulgence in relating outputs to input costs (costs to benefits) that rendered them inappropriate for social planners. There is no disputing the need to



know what it will cost to undertake a programme and what is likely to come out of it. It is however equally important to know that costs are not the only concern of social planners, neither are they easy to identify and to know who should bear them. There are serious difficulties in imputing cost values to health projects just as it is difficult to place values on benefits. This is essentially because it involves value-judgement which varies from person to person. Conventional health systems did not seriously consider who should bear health costs and who benefits most from health projects before imposing charges or fees. The Zimbabwean experience showed that the mining companies who should have borne the cost of pneumonia and scurvy costs to the individual miners, their families and the economy as a whole, were not made to pay. Neither were the victims compensated or for that matter, provided with some medical care in their places of retirement, the rural areas. The requirement to apply monetary measures on inputs and outputs, and the need to put a time perspective on costs and benefits, all tend to weigh heavily against health preventive and promotive measures in favour of curative medical care under the old approaches to planning. Typical old styles of health care planning concentrated on what facility W's performance this year was in terms of how many outpatient or inpatient attendances of which n cases of disease y where discharged in Z days at a cost of p. They glorified medicine \_ the noble art of curing disease and repairing, removing or replacing malfunctioning parts, hence they were termed 'reactive health services' (1).

1. Ackoff, R. "Redesigning the Future".

This system implies that the amount and quality of services available to an individual is proportional to his ability to pay for it. So called control programmes, since their benefits were not measurable except as cases of bilharzia, malaria etc seen this year, were given little attention. The benefit of good health from prevention and promotion were no entitlement to an increased share of the budget. The personnel involved in these activities were not as recognised as surgeons in the central hospitals and special institutions. An intermediate form is what might be termed 'preactive health services', which emphasise preventing illness and injury than curing them, developing immunisation, early detection through thorough check-ups. The concern here is in minimising or eliminating the effects of illness and injury through research and application of technology. Its main shortcoming is that it does the aforementioned without fundamental changes in the social system that produces the conditions. It thus supports private and governmental health financing schemes within existing institutional arrangements.

As Rene Dubos (1969) observed, under the above systems, modern medicine developed to become too technological and over-specialised. This is partly because it is based on an 'engineering' or 'mechanical' approach that is geared to salvaging and putting right 'a car' when something goes wrong, not meant to ensure a continuous and favourable interaction of people and their environments. The latter would promote positive health. Whereas traditional medicine placed responsibility for a person's illness into the family and ultimately the community, modern medicine concentrates on the individual, is increasingly becoming expensive and sophisticated and medical knowledge is becoming



more and more mystified and concentrated among experts. Instead of institutions being made to suite the requirements of the patient afflicted, they are being designed more and more in line with specialist requirements (Unit for the Study of Health Policy, 1976).

There is relative acceptance of the necessity of a certain amount of medicine, scientific and modern, but this however should be more humane, ecologically sound and less technologically-dependent on their mode of delivering those 'containment and caring' health services that we need. This would rightly place health and health care in the broader arena of society where it belongs. It is no longer the monopoly of the medical profession but of all relevant professions. The term 'interactive health services' has been used by some to describe the type of care that emerges from here whereby the planners take a broad view of the health system and the effect of the environment and wider society on it.

The model being proposed here accepts that there is validity in comparing the cost of one vaccine to another, relating changes in infant mortality rates to budgetary allocation to programmes for child care, maternal perinatal mortality and morbidity to MCH etc. It however goes further than that and states that these are not the only considerations nor are they the major considerations. What it submits is the need to view the wider environment, at the centre of which is the human factor, who is the crucial determinant. The human element does not exist in isolation. It does not function in a vacuum and the behaviour is not deterministic. (Unit for the Study of Health Policy, 1976: "Health, Money and the National Health Service").

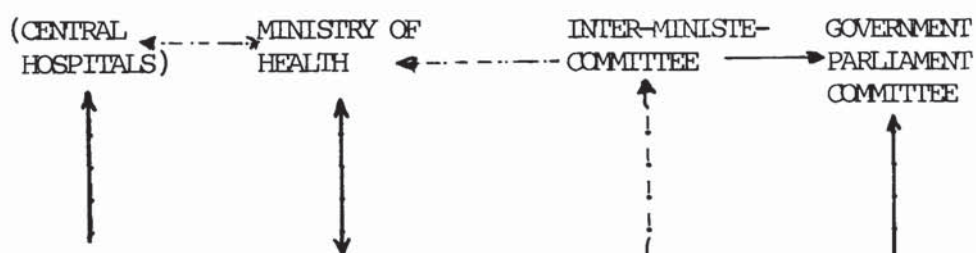


Diagram 8.i

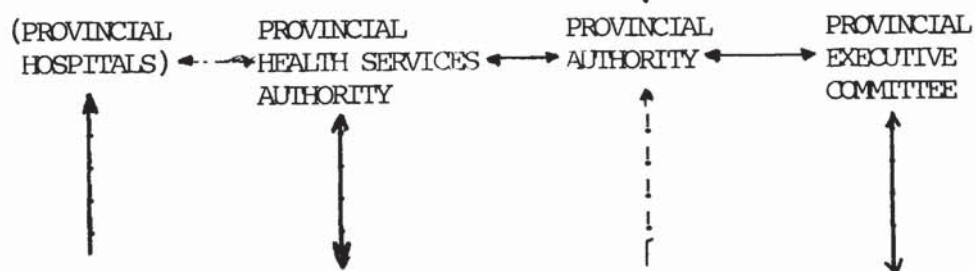
HEALTH CARE SECTOR PLANNING AND MANAGEMENT STRUCTURE

!LEVEL OF CARE!	!HEALTH MANAGEMENT!	!MULTI-SECTORAL!	!POLITICAL!
! (UNIT) !	!TEAM-EXECUTIVE !	!COORDINATING !	!STRUCTURE!
!	!AUTHORITY !	!BODY !	!
!	!	!	!

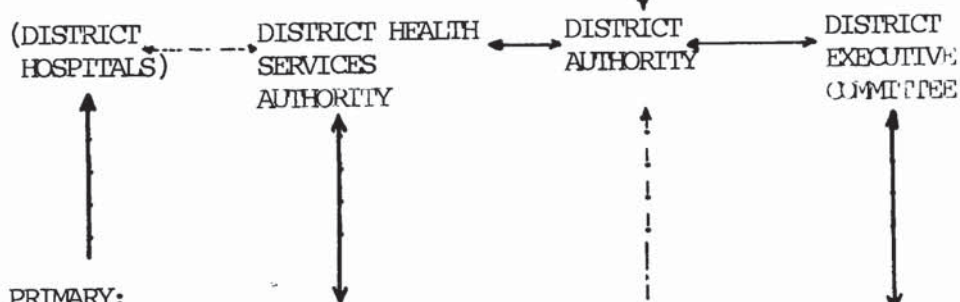
QUATERNARY:



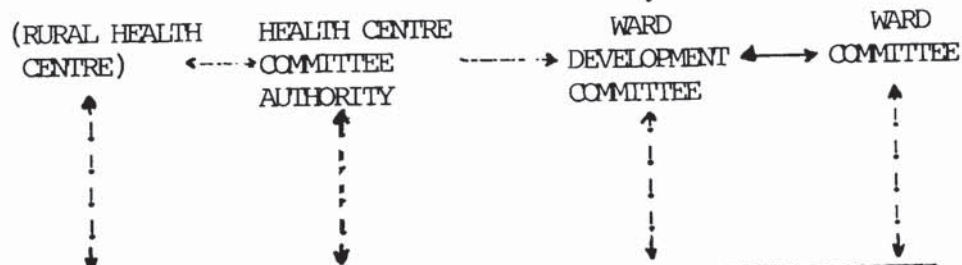
TERTIARY:



SECONDARY:



PRIMARY:



! VILLAGE COMMUNITY AND STRUCTURES, AND VILLAGE HEALTH WORKERS FORM THE UNSHAKEABLE BASE !

It is the contention here that health planning should be people oriented. It should be geared towards the needs of the majority of the people who often are poor and rural based in the underdeveloped countries. To ably cater for them, the planning process should start with democratic consultations at the community level. Perhaps even more important is that there should be instituted conducive political structures that are facilitative to the establishment of that (See diagram 8.1). The development of democratic organisations is crucial to a shift towards greater social responsibility which is key to human advancement. Involvement and participation develops that badly needed level of awareness that is critical if people are to mature to self actualisation and self sufficiency.

Planning in the health care sector can take a leading role in providing this opportunity through increased government support for participative planning which has its foundation in community involvement. At local level, communities should have the power to submit their own priorities and to draft and propose their own plans with government expert support through decentralised management structures. Inevitably, these new centres of political power have no sizeable resources in the form of finance and sophisticated equipment to inject into the health systems, besides their labour. If, irrespective of this, the populist governments in underdeveloped countries that have been put into power by peasant and worker support, adopt approaches that ensure that these groups have a greater say at their respective levels, they would have attained a measure of redistribution. By holding expansion in the already existing, often urban based, sophisticated facilities and channelling the newly

qualified manpower and newly created resources in the form of support equipment etc to the periphery, they pursue equity objectives. The challenge lies in ensuring that these hitherto disadvantaged communities channels to contribute to policy making (especially in matters that affect them) remain open and effective. From the political structures, elected representation from grassroots to the central representative body attempts to ensure that they have a voice to counter the weight of the outspoken privileged groups and thereby guarantee that they are heard.

Besides the access to say at high levels, the additional resources tapped through community contribution (these escape the taxman) would release otherwise earmarked resources at the centre for other development activities. In a call for the institution of a health promoting economy the like of the preceeding account, the Unit for the Study of Health Policy (U.K), 1978, stated:

"...if we are to create a health-promoting economy, if we are, negatively to remove the conditions perpetrating much current illness, and positively , to make it easier to lead a healthy and satisfying life, then every individual and every institution must re-assess social goals and values..."

Hitherto, the socio-economic environment has been producing ill-health, stress and debility while medical care has been functioning inappropriately to cope with this. To correct this dichotomy, requires stronger intervention to change that environment. It is postulated here that the political intervention, if adequately informed, seems



likely and perhaps the only one, through health, capable of bringing about the fundamental change in question.

In the case of Zimbabwe, the political will to intervene came about in 1980 with independence. Unfortunately only the minister and deputy minister had the orientation at the top of a civil structure run by an entrenched group of whites. These had neither the interest and knowhow nor the inclination to adopt planning and management structures that would enable redistribution of care to the disadvantage urban and rural majority.

It therefore behoved the political leadership with the advice of an expert in the Minister's office - then not an establishment post - to effect the new approaches. I was taken on to perform the role as Special Assistant to the Minister. What then were the challenges and how did we face up to them?

(iv) MANAGING THE HEALTH CARE SECTOR:  
THE REALITIES OF POWER AND CHANGE.

"From their separate points of view, both sociologists and economists want to introduce a degree of rationality into the process of health care delivery. The former strives for a more equitable distribution of medical resources, a universal right to treatment, while the aim of the latter is the good management of the public funds applied for this purpose. Their approaches can be directly applied to the problem, often by legislation with a greater or lesser degree of success. However, such intervention tends to change the nature of the imposition of new constraints. The carefully thought out project thus becomes distorted as the system does not function quite in the way foreseen, its aim is deflected by the often subtle and sometimes hidden workings of the institutions involved against which sociological and economic theory can do little." (Denise Deliege: "Socio-economic theory and practice in Health care delivery", Social Science and Medicine Vol. 12, pp.1-5, 1978).

The discussion in this section will start by recognising the significance of the health planning and management model the preceeding section proposed. In essence it proposed the introduction of 'a triple structure' interactive consultative model of health care planning, management and provision. This model as depicted in diagram 8.1, recognises a referral structure under a health management team which has executive authority; a multi sectoral coordinating hierarchy and a political hierarchy. It is significant from viewing this elaborate structure or diagram that it is the village community and

structures that form the base and reference point. This is the essence of 'bottom up' planning if the shown structures are actually made functional. The three main organisational structures, which do have horizontal linkages, show provision for accountability to the population's representative institutions. Assuming that democratic processes that constitute the cornerstone of the ZANU government policy do occur, these representative institutions guarantee health care sector accountability to the population it serves.

Good health care management needs imaginative innovation and the careful evaluation of different patterns operational in different countries. An approach that has sufficient flexibility to cope with local variations and capable of assimilating new ideas as they come would be preferable. This however seems to require the setting up of an inter disciplinary planning core at the centre or the national level. Besides thwarting the physicians tendency to want to dominate health services, this would ensure a balanced approach to the problems of ill health as we know them. The core would be charged with the task of monitoring local conditions and atuning plans accordingly in consultation with the authority concerned. It would be further their responsibility to feedback to the authorities on a regular basis how they are performing. At the centre, they will ensure that resources are made available to support those areas that are worse off. They also monitor larger investment programmes to ensure that they conform to national priorities and equity objectives. The other priority at this national level would be to set up facilitative and functional units within the health services structure, even if these be transitory in nature. Whereas provincial authorities did exist, their



influence remained minimal because of their inability to command and disburse resources. They needed a relook. The real situation indicated that District Councils were the ones legally vested with the authority to actually command resources and approach the ministry with requests or observations. Below them, the Health Centre Committee and Branch Executives, although they are active and influential, have no legal status as yet. This aspect requires concerted efforts from the many sectors that work with and through them. For the health services, the Village Health Workers (VHW) programme's success, depends on this level of organisation to identify the people who would dutifully serve them and whom they can chase up and make accountable. The ministry of health will in turn train them and send them back to the community that selected them; while local government will disburse the salary or allowance they are entitled to. Whereas the community supervises VHW day to day work, the health services referral structure ensures professional supervision including in service training. The Rural Health Centre oversees and supervises the VHW, including the provision and replenishment of kits. The Rural Hospital, where it exists organises the in service training on an area by area basis. The frontline staff manning these two lower levels, i.e. Rural Health Centre and Hospital, are trained (in service) and supervised, by the District Health Team who in turn are so trained and supervised by the Provincial Team and ultimately by the centre.

In reality, the setting up of the core as the first move was not inconsistent with 'bottom up' planning nor does it undermine or contradict community participation in management. The essence of the matter is that the national level had to make the first moves because

it is the one that was charged with that responsibility. Besides, in our particular case, popular representation started from the top. There was therefore an imperative need to establish a functional unit, purposeful, legal and more importantly, able to steer the ministry through the transition and to set guidance for the rest of the lower levels.

The management mode that could best cope is one that emphasizes decentralisation. Decentralisation is a way to increase the responsiveness of governments to those it serves and should involve those outside government, whose active support is often necessary to promote health. By outside government here is meant those functional social structures, no matter how much they contribute; which are not constituted or are expressly excluded, by a statute of parliament. This by definition places the Branch Executive, Ward Committee and Rural Health Centre Committees, the hub of PHC; at the forefront. The lack of statutory existence does not necessarily imply illegality, non functionalism or marginalisation. Community organisation's informal yet powerful character, though arising from party activities, lays the foundation for the formalisation through statutes. It is therefore the community organisation that is the cornerstone of the endeavour, so long as the political leadership in government, who derive their power from the leadership of the party; still owe that leadership to the masses. By instituting decentralisation, the leadership builds in a measure of functional responsiveness.

The key factor here remains the need for political commitment by the leadership to improve the conditions of the poor often rural based

people. Having said that, assuming the commitment is there, is there sufficient management know how to actually effect decentralisation? Is it sufficiently understood as a concept by even the most well intentioned of senior civil servants?

Decentralisation can be one of three things:

- (a) deconcentration - i.e. transferring resources and decision making from headquarters to other branches of central government;
- (b) devolution - i.e. to autonomous units of government such as municipalities and local government;
- (c) delegation - i.e. to organisations outside the regular bureaucratic structure, such as regional development authorities.

In practice however, the three forms are often combined: responsibilities for executing development projects might be given to provincial offices of central government (deconcentration) to work with local government (devolution) and with the community (delegation).

The process of decentralisation has succeeded where governments felt a bit more secure. Weak governments cannot afford to decentralise; they tend to pull control towards the centre. It is an incremental process of building up the capacity of organisations to assume greater responsibilities. Our structure seems to be geared towards that. Besides, the unevenness of health care provision nationally and by different levels seems to indicate that it was the one best suited approach. With the primary level of care consuming a mere 13% of total



health expenditure in 1980/81 and yet expected to cater for the majority of the population, decentralisation could perhaps be followed by an increased shift of resources downwards.

As head of the forward team into the sector, I felt the approach was attractive to employ. Further, our choices were limited since we were mandated to transform health care provision in Zimbabwe radically. The Minister, in addition, was ZANU's Central Committee Secretary for Health whose manifesto directed him to radically change institutions, mechanisms, personnel and styles of health care delivery to ensure 'equity in health'. As a member of government, he was at the same time expected to uphold the provisions of the Lancaster House Constitutional Agreement (1979) which guaranteed public service jobs and continued functioning of Commissions such as the Public Service Commission, which stood for protection of the status quo. This presented a dilemma, an ideal situation for applying the analysis of options technique.

The major challenge which had to be faced up to hinged on:

- (a) the need to reorganise the health planning and management structure so as to introduce one that is sufficiently democratic to allow grassroot participation,
- (b) the need to ensure that drug supplies were getting to those clinics, rural hospitals and mission hospitals that had re-opened since these were the most peripheral and therefore the most accessible to the rural population,
- (c) the need to ensure the integration of the ex-guerrilla military medics to ensure that rural provision was expanded

and new government policies of community involvement in health provision were explained by these cadres who knew and came from these areas (during operations or by birth).

(a) The Reorganisation

The World Bank (1977) recognised the contribution to health care that results from good organisation of health services when it noted that (See Chapter VI: "The Ineffectiveness of Health Care Organisation", inside). " .... the most persistent problems in improving health do not result from the complexity of medical technology, and only partially from the scarcity of financial resources: rather, they derive principally from the problems in the design and implementation of policy, management and logistics."

There is wide acceptance of the view that these organisational problems have, in the main, been the result of the leadership of the physicians in health care matters. Their failure as managers in health services have been aptly ascribed to their inability to:

" .... understand and direct the forces which interact in directing and controlling the health services." (See Chapter VI inside).

These forces happen to be socio political. Since these issues have been adequately dealt with elsewhere in preceeding chapters, it is the intention here to view the interventions made in the particular situation in Zimbabwe in 1980.

The essence of the reorganisation was two fold: firstly, it was to ensure that the white dominance of the health care sector, given their unavowed opposition if not downright hatred of the Mugabe government, was diluted; secondly, it was to ensure that the process of decentralisation was embarked on as the only sure way of ensuring that the people had a full say in matters that affected their health, through the health care structures. Decentralisation would have ensured that new resources were channelled to the needy rural populations since its major attribute was the strengthening of rural oriented preventive, promotive and rehabilitative activities. Decentralisation being a concept, required functional structures to effect it, especially those aspects of it that called for actual and immediate action. In our case, as noted earlier on, the start had to be from above. The fact that the Minister and his Deputy were the only people representative of the new government views and policies meant that some measures - 'unofficial', because they were not sanctioned by the official PSC; had to be taken if any moves for the better were to be effected. This view led to the setting up of 'organs' or appendages to the system at a level between the Minister and the ministry. The Planning Pool was one such organ. Whereas it provided a forum for discussion between the catalyst in the Minister's office (my role) and the service hierarchy (the ministry), its by product the Programme Implementation and Monitoring Unit was supposed to go beyond that and actually move into the field granted the authority and recognition. Through built in mechanisms like the Planning Pool Programme Implementation Unit, the political leadership would have had constant feedback on progress regarding programme implementation.



This form of organisation, whereby the top has access to the grassroots through an established unit that is not accountable to the hierarchy, acts as a monitor, a check on bureaucratic performance. By making on the spot assessments, interviewing communities across the country on an ad hoc basis, they obtain information on the people's actual impressions of the service performance. Claims that surveys and evaluations would bring this out, while they have some validity, may not be as effective, when it comes to speed of disclosure and follow up on actioning. This came out during my field work activities in Charter District (now Chivhu) which were part of continuing research carried out with the view to assessing, among other things:

- (i) the extent of the damage to clinics - buildings, equipment, etc. and the estimation of costs to repair and restore them and how long it would take to re open them;
- (ii) whether or not the staff was still available or in their respective posting to enable re opening;
- (iii) the major health problems and demand for services as shown by the attendance register;
- (iv) the nutritional status of children in the catchment areas (through assessment of grade 1 pupils in schools);
- (v) the drugs supply position and whether the mechanisms for further procurement were operational;
- (vi) the nature and level of community organisation in a bid to determine what programme 'entry levels' were likely to be effective in the short term;
- (vii) where no health facility existed, what the source of care was i.e. the traditional healers and traditional birth attendance level of activity and their attitudes to government drive

towards equitable provision of care and recognition of traditional care and practitioners;

- (viii) the attitudes of the community organisations and the community to the government sector's expressed intention to develop the rural areas and what in their view needed to be done to either modify them to be relevant or where they were relevant, how best to actually effect them.

Earlier discussions in chapter V and VI dealt with the details of the findings. It is the intention here, under the three section headings listed above, to deal with the corrective actions taken and how they were planned and decided on. The sections are: the structural organisation, drug supply and manpower.

What difficulties would be expected in undertaking a re organisation? The trauma that accompanies massive 'top down' organisational change may be a source of poor performance among the old staff members. The current economic recession, because of its severity, may create uncertainty. This may arise from the inadequacy of national resources and may be further complicated by the complexity of accumulated health problems and entrenched attitudes of the different population groups to be catered for. The likelihood of spontaneous support for new proposals or modes of operation is consequently more remote. It is because of this realisation that political modes and techniques of planning and management interventions are resorted to. The techniques proposed recognise the political nature of the existing systems and the structures therein. The attitudes of those who designed them to sustain their power are unlikely to change overnight just because they

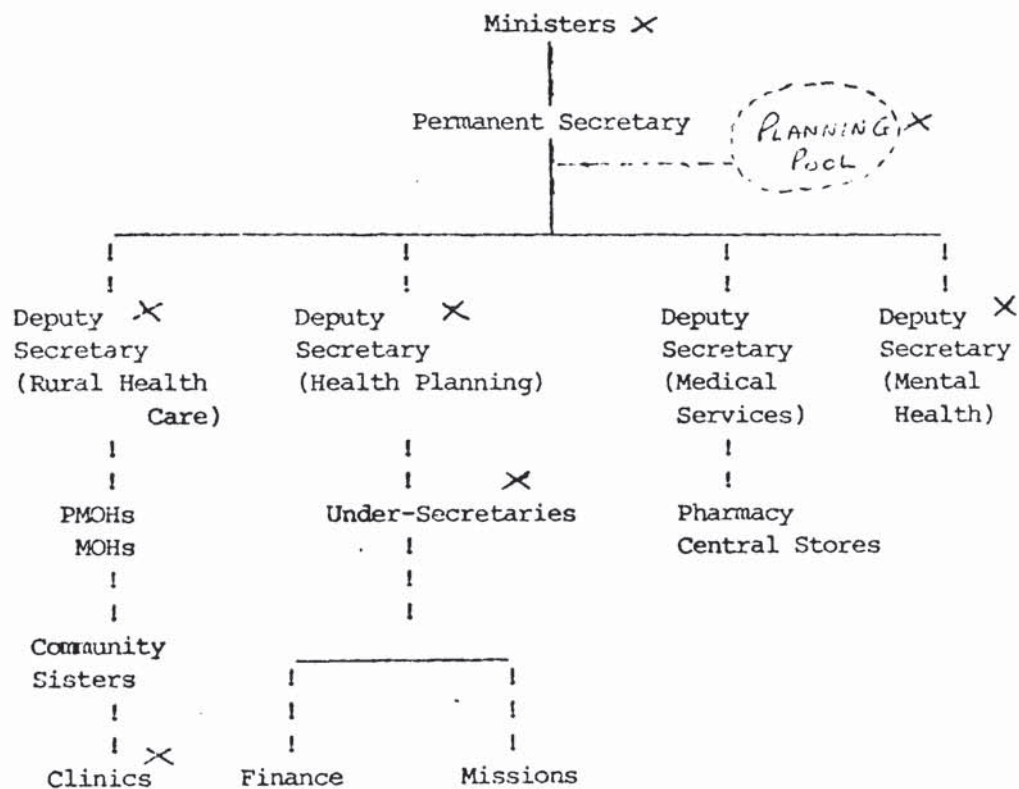
no longer have the power. Managing the change process requires skill. When necessary, 'looping', the practice of circumventing those senior staff members who uphold the old regime's views and are slow in adapting to change, was used. This was successfully done at the periphery, i.e. the provincial and district levels, it could not be equally successfully done at the head office because there were no senior African staff working there at independence. Here, direct new appointments had to be made, through the Presidential directive on supercession. The directive provided for the appointment of suitably qualified people into promotional posts, over and above long serving staff members. This move had a dual purpose - to ensure the employment of sympathetic people in senior enough positions to be effective, and to force the uncooperative 'Old Guard' to resign or retire.

The organigram 8.ii shows the new structure of the Ministry of Health. In diagram 8.iii is shown the changes made at the top of the Ministry in a bid to establish a more responsive team to effect the new health plan. Besides the drive to control the civil service, especially the 'Old Guard' within departments, there was also the drive to establish the role of the party. To break the white axis (including those blacks that sympathised with their policies) the move towards 'party involvement' seemed the most attractive. This would mean party 'grass roots' intervention in economic and socio political issues rather than its confining itself to winning elections. Under it, government programmes and public officers (including party sympathetic appointees) would be under public scrutiny.



ORGANIGRAM 8.iii

ORGANISATION OF HEALTH



Note: ZANU-sympathetic areas are marked with a cross.

On their side, the whites would tend to hang on to their supremacist aspirations resorting to the safeguard of the constitution. As is shown in the simple game model 8.1(i), the two positions seem irreconcilable. It was the view on balance that the issue should be taken up in singular approaches, subject by subject, within ministries and to resolve specific problems foreseen or being experienced.

A number of relevant questions remained however which had a bearing on health policy. Although these are raised here, this study did not comprehensively analyse each one of them. These included: What strategy can be designed to diminish the Nkomo supporters' discontent since these could be valuable allies? If the ZANU leadership is determined to maintain the 'party state' idea, is the party being organised sufficiently effectively to take on this role as shown in the 'triple structure' proposal? How is this affected by the Public Services Commission (PSC) regulations on political activities of civil servants? Is there a well designed policy to try to keep the Western sympathy despite radical ZANU moves, and if so, how is it likely to affect both ZANU and the West?

Admittedly, the structural re organisation was intended to introduce a new, more representative style of management and administration of health services. The divisional and unit concept places the burden on those heading them to be fully accountable and responsible for those activities designated to be under their control. By appointing sympathetic people to head these, it was hoped that the ministry would effectively carry out its programmes. But structures, job descriptions and qualifications can look perfect on paper, when the human factor is

introduced, the outcome is not so easy to determine. Once the organisation is in motion, no matter how well and efficiently reorganised, the final outcome is indeterminate. From the mere understanding of the structure, one cannot predetermine the outcome in performance. It is this realisation that has led to the development of techniques like analysis of options which enable you to constantly and continuously monitor and 'fine tune' the organisation.

Through fieldwork attachments ranging from six weeks to three months at a time, as researcher and Special Assistant, I assessed the likely impact of the reorganisation both before submitting the organigram for approval by the PSC and after its approval and staff appointment. The findings showed some of our earlier errors which were perhaps to be expected but the most revealing was that people once in posts may produce a different organisation from what was initially thought to be the way it would function. This was evident at lower levels as well as at higher Provincial and National levels. Because the staff even though genuinely sympathetic were trained or so used to doing certain activities in a certain manner, they could not without re orientation and retraining perform as expected under conditions of change. Even the new recruits would require steering and guiding, so the approach which enables a planner to watch the organisation while in motion, still holds most potential - at the start and when in motion.

#### (b) The Drug Supplies Analysis

This analysis tried to examine the problems of implementation that faced the new minister and his small team. To actually implement the



Primary Health Care approach adopted because of its special emphasis on rural provision; the 'Old Guard' Permanent Secretary and Deputy Secretary had to be outflanked, circumvented and outnumbered. The new Divisions of Rural Health Care, Health Planning and Mental Health, each headed by a newly appointed Deputy Secretary, were intended to achieve that. Nevertheless, key areas remained under Old Guard Unit heads' control. These were: the finance section through which all disbursements are made (this was despite the section coming under a ZANU sympathetic Under and Deputy Secretary), and the Pharmaceutical and Central Stores section who are responsible for all drugs purchases, distribution and storage. The latter fall under the Old Guard Deputy Secretary for Medical Services.

The move to make health care more accessible to the majority of the rural poor came with the introduction of the partially free health services in September, 1980. All those earning Zf150 or less were eligible for free care inclusive of medical examinations, drugs, equipment, in patient care, etc. Besides the increased demand for staff this created (this is dealt with in the next section), the immediate and pressing problem faced was to increase the supply and availability of drugs and equipment. The reopening, repair and reconstruction of clinics, rural and mission hospitals, which are all located in rural areas had gone on at a very fast pace. This had raised the people's expectations and left the ministry under a lot of pressure to provide the care the population now demanded. These facilities however remained the most disadvantaged. The drugs were not getting through. The method of drug ordering, delivery and payment to the private companies that provide them had not changed with the

change in emphasis. Besides, there was one big supplier which is a subsidiary of a South African based company. The finance and central stores units continued to process orders and invoices in the old manner. The Old Guard, under the reorganisation, were left inadvertently with all the power to frustrate the Minister's efforts. They remained with the opportunity to discredit him and his policies.

The budgetary submission for the financial year 1980/81 had been prepared with the view to obtaining government sanction to radically change the mode of health care provision. Sizeable resources (Zf25m) were granted for rural services strengthening. But of this amount, the major users - local authorities (clinics) and missions had only spent Zf4m by the end of December, 1980 (halfway through the financial year!). At this rate of expenditure, the Minister (considered one of the most effective ZANU ministers) would find it hard to justify an equal or increased allocation for the future years and besides, he would be discredited for having failed to provide care with all the funds he had requested. Already complaints of lack of drugs, equipment and manpower were being voiced from the rural areas. This fitted well with the aims of the Old Guard and put us in a difficult position.

With the clinics' and missions' expectations raised to the level that they now were from parliamentary pronouncements and policy statements, the unavailability of supplies and support placed them in a dilemma. They however had to be encouraged to demand drugs and equipment otherwise there would be no increase in supplies with the consequence that in the face of such grave need, the budgetary allocation would remain unused! With the established practice that all unutilised funds at the end of the financial year have to be returned to treasury, this





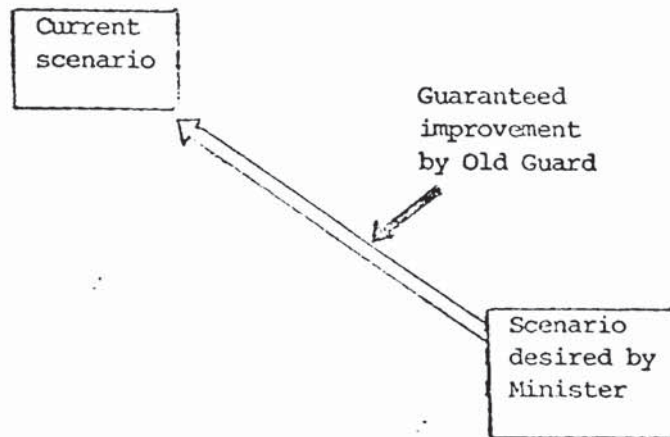
situation spelt disaster for the rural health services. The analysis shown in tableau 8.a was done to enable us to understand this situation and seek to resolve it.

#### The First Analysis:

The current scenario shows that the minister is encouraging demand, the clinics, missions and Provincial Medical Officer's of Health (PMOHs) are transmitting the requests, but the 'Old Guard' is not supplying the drugs. The 'current scenario with dampened demand' means that the minister would stop encouraging increased demand for supplies. The Minister's option here is whether to encourage demand from the clinics and missions, which in turn have the option whether to send up these demands. The assumption is that their demand for drugs depend partly on them, partly on the Minister's encouragement (i.e. 1/1/1 in the first three places means considerably more than 0/1/1). The PMOHs have an option whether to transmit the demand to the Finance section. Finally, the Old Guard in Finance and Stores have an option whether to supply the demand or to delay and frustrate it.

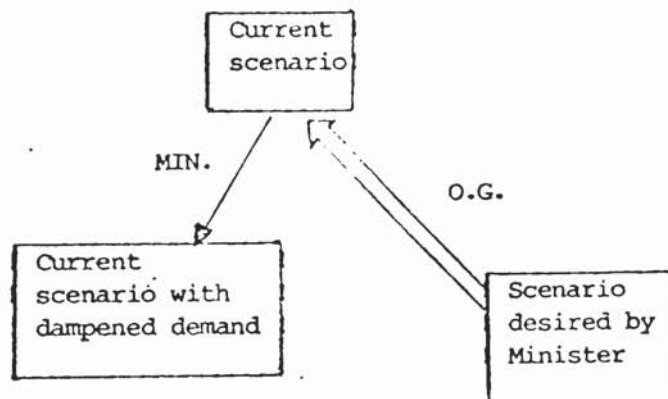
From the scenario desired by the Minister (demand encouraged, transmitted and supplied, as shown in the third column from the right), it appeared that the 'Old Guard' could guarantee a scenario they preferred by not supplying the demand. This created a preferred scenario whatever the other players then did, but immediately it led to the current scenario. This is represented in the strategic diagram 8.iv. The situation that arises is depicted in strategic diagram 8.v. This analysis was not pursued further, other options had to be considered by which the minister might escape from this trap.

STRATEGIC DIAGRAM 8.iv



Thus in this model, the Minister could not achieve his desired scenario. On the other hand, from the current scenario, with its danger of frustrated expectations, he might prefer to not encourage demand. Adding this to the above diagram, we get the following:

STRATEGIC DIAGRAM 8.v



The sour lesson learnt from the above was that the strategy to generate increased awareness, a demand push from below for increased and better care, could rebound if the capacity to respond does not exist. If the existing channels and hierarchy decides to be obstructive, rising expectations remain unmet and create disillusionment followed by anger and rejection. Through systematic delays on requisition processing, orders placement, deliveries delay, etc., the Old Guard could actually discredit the minister without being themselves implicated.

In the quest for other options, the possibility of further organisational moves to 'take over' or 'by pass' the Old Guard strongholds presented the best alternative. This however is a long term objective yet the situation required immediate action. There was a need for a bargaining 'chip' to obtain short term result yielding concessions from the Old Guard. The organisational option's other disadvantage was that it did not solve the immediate problem of budgetary utilisation.

Another possible option open to the Minister as Secretary for Health in ZANU was supplying drugs from the party stores or other sources open to the party. This would have met his short term needs, bolstered support for his stance and exposed the Old Guard, who would show him as unwilling to work with his officials and thereby discrediting him as flouting constitutional provisions and embarrassing the government. The Old Guard's aim was to demonstrate that the Minister's radical approaches did not work and that they, not him, still had the power to effect any changes. This further reflected the extent of their



unwillingness to change.

## The Second Analysis

The search for a feasible option led to the consideration of the possible option of 'direct supply' of drugs from the drug companies to the clinics and missions. This would be consistent with the ZANU principle of 'centralisation of policy, autonomy in implementation'. But it could be justified primarily as a short term measure given the evident incapacity of the present system to meet the current drug needs of the rural areas. It would mean distributing requisition forms to clinics and missions, which would then take them to the drug companies to obtain the drugs they need. The drug companies would bring the completed forms to the Ministry's Finance section for reimbursement.

Under this approach, difficulties can be expected from two sides. There are possible organisational and communications problems in printing and distributing the requisition forms and getting clinics and missions to use them. Printing the forms might be done through UNICEF sponsorship, distribution could be through the PMOHs or through the ZANU organisation. The implicit threat of using the latter channel would probably ensure that the former is used properly. The bigger and better staffed missions and rural hospitals might collect orders from each area to take to the drug companies, a procedure in which they already have some experience.

TABLEAU 8.b

MINISTER

1. Organise direct supply	0	1		1	1
2. Release foreign exchange	0	0		1	1
3. Pay higher prices	0	0		0	1

OLD GUARD

4. Supply normally	0	0		0	0
5. Reimburse companies (if)	0	1		1	1

COMPANIES

6. Supply normally	0	0		0	0
7. Supply direct (if)	0	1	$\xrightarrow{c}$	1	1

Current  
scenario

Release  
foreign  
Exchange

3

Direct  
Supply

Release  
foreign  
exchange  
and raise  
price

Note: c - Company preference move  
m - Minister preference move

Another kind of difficulty could be expected from the drug companies and the Old Guard. The options shown in tableau 8.b are used to examine this. Our thinking here was that, first the present hold up might be due to either (or both) of the Old Guard and the drug companies not supplying adequate amounts through the normal channels.

For 'direct supply' option to be implemented would require the drug companies to supply against requisition forms (option 7, conditional on option 1) and the Old Guard to reimburse the companies (option 5, conditional on option 7). It was felt that the companies which stand to profit from the extra supply of drugs would favour such an arrangement. They might voice some objections on the grounds that the foreign exchange to enable them to meet the increased orders was not available and that higher prices would have to be charged for extra work and handling charges for smaller than usual orders handling.

From the above, it was the view that the minister despite the limitations of staff then, could do what was necessary to organise for the forms distribution etc. For options 2 and 3, it is difficult for the minister's aides to assess objectively whether claims for more foreign exchange and raised prices are genuine, in the time available. Conversely he cannot just accept the word of the drug companies. For foreign exchange, Treasury and Cabinet authority are required anyway. But since they were willing to give a two-and-a-half fold increase in budgetary allocation to the Ministry, this might just be granted. The old guard and companies were not taking their options 4 and 6 for whatever reason. Option 7 consists of the companies supplying drugs



against the completed requisitions. If any one of these two options is not taken, a hold-up would result.

The 'current scenario' was that no options were being taken i.e all 'o's in the column. Direct supply would be options 1 and 7 taken, with 2 and 3 taken or not. The relevant question at this point would be whether or not option 5 is essential to make direct supply effective.

The old guard are able to hold up orders of drugs when they come piecemeal, consisting of many orders for small quantities, partly because the Minister cannot chase up every order and partly because he is not familiar with the financial procedures which the old Guard operate. But the drug companies are headed by one large supplier, a multinational corporation that is familiar with the procedures involved and can go to the Minister with a consolidated request for reimbursement. Given these facts, it seemed the old guard could not hold out for long against the drug companies' requests for reimbursement backed by the Minister, and consequently that a '1' (yes) option 5 is not essential, though desirable, if direct supply is to be effective.

For the purposes of further analysis we simplified and generalised our options to make the model more useful. 'Direct supply' as a means of circumventing the old guard was termed 'special measures' to allow substitution by any other measure which was felt to be as applicable. Any measure however would depend on the cooperation of the drug companies who must be induced to supply the drugs. Options 2 and 3 could come under 'concessions' to the drug companies to get their

confidence and cooperation however there was no knowledge as to the necessity of these. The old guard and the companies were each given one option \_ 'cooperate' with the minister's policy, whatever it might be \_ i.e. normal supply, direct supply or other special measure. Consolidated tableau 8.c shows the preferences of the different players that can be made (for each player (s) columns to the left are preferred to those to the right). The strategic diagrams 8.vi represent the possible moves.

The diagrams indicate that by cooperating with the minister's special measures, the companies can reach a guaranteed improvement (a position which is better, regardless of the other player's reactions) together with the minister. The assumption is that the companies will gain (profit-wise) from the budgetary allocation spent, rather than refunded (because of non-use by the old guard), and the minister will gain from this too even if he has in the process to give special concessions. Whether the companies would also gain if the concessions are not necessary depends on the unknown factor of whether the concessions are economically necessary. It is however safe to assume that increased trade would benefit both in the end. It is important to stress here that the conclusion was reached that profit comes first for this major supplier, even before the objective of the parent company's government (South Africa) to destabilise Zimbabwe. This was shown by their offer to government to obtain shares of their company (Government now holds 41% of the shares),. The potential of markets up north remained extremely attractive.

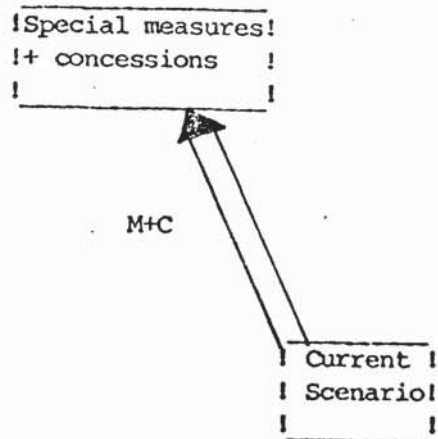
TABLEAU 8.c

		Tableaux			
		1	2	3	4
MINISTER					
	Special Measures	1 1 -	1 -	- 1	1 -
	Concessions	0 1 -	1 0	- 0	- 0
OLD GUARD					
	Cooperate	- 0 -	- 0	- 0	- 0
COMPANIES					
	Cooperate	1 1 0	1 0	0 1	1 0
		Pref'd by Minister	Pref'd by Minister and Companies	Pref'd by Compa- nies if conces- sions are neces- sary	Pref'd by Minister and Compa- nies if conces- sions are unnece- ssary

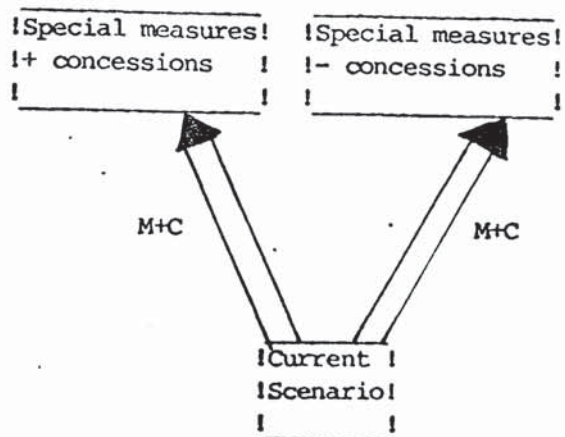


STRATEGIC DIAGRAM: 8.vi

If concessions  
are necessary



If concessions  
are unnecessary



These diagrams say that by cooperating with the Minister's special measures, the companies can reach a guaranteed improvement (a position which is better, regardless of the other players' reactions) together with the Minister. The assumption is that the companies will gain (profit-wise) from the budgetary allocation being spent, rather than wasted, and the Minister will gain from this also, even if he has to make special concessions. Whether the companies would also gain, as in the lefthand diagram, even if no concessions are made, depends on the unknown factor of whether the concessions are economically necessary. But it is safe to assume that the volume of trade would bring benefits to them in the end.

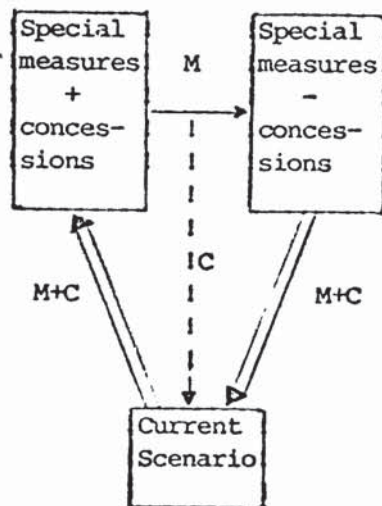
The essence of the matter is not however so simple. The company, in discussions and bargaining, would require assurances and guarantees often beyond the ministry of health and also maybe, requiring him to face up to his civil servants. The establishment of mutual confidence trust in the intentions of the parties and the existence of benefit for both parties would see them build a long-term relationship. Whereas the minister would of course rather not give concessions, this would lead to the company withholding cooperation which would bring him back to the unpreferred 'present scenario'. The threat of withholding cooperation by the company is sufficient to deter the Minister from withholding the concessions as is shown in strategic diagrams 8.vii.

The left hand diagram reflects the assumption that economic concessions are necessary while the right reflects the opposite. There is however an important element in the left hand diagram \_ the reaction of withholding cooperation if concessions are not assured is quite inevitable. The companies therefore, must be strongly reassured, even from other key ministries like the Treasury and Finance, about concessions if they cooperate fully. The righthand diagram shows that non cooperation is not very credible as carrying it out would not be in the companies' interests. The 'current scenario' here acts as a confrontation point from which either party may refuse to budge during the bargaining process in the hope that the other party would give way first. These moves, it should be restated, are bargaining moves in the negotiators mind and tough bargaining does not indicate unwillingness to abide by an agreement, once made; it is on this that the companies will require reassurances.

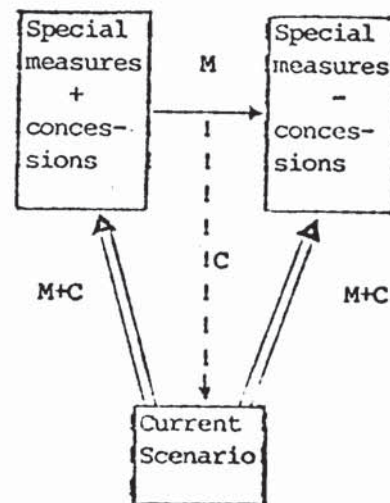
STRATEGIC DIAGRAM 8.vii

Thus the threat of withholding cooperation is, if credible, sufficient to deter the Minister from withholding concessions. We show this as follows.

If concessions are necessary



If concessions are unnecessary



Again, the lefthand diagram reflects the assumption that concessions are economically necessary for the companies, while the righthand one reflects the opposite assumption. But now there is a crucial difference between the two cases.

In the lefthand diagram, the reaction of withholding cooperation if concessions are not assured is quite inevitable. The companies must be strongly reassured about concessions to make cooperation possible.

In the righthand diagram, the threat of withholding cooperation is not very credible, as carrying it out would be definitely against the companies' interests. The current scenario here acts as "a confrontation point" from which either party may refuse to budge during the bargaining process in the hope that the other party will give way first.



In terms of progression, the strategy is to try and hold out for cooperation without concessions. If this seems unobtainable, this maybe because they are economically necessary and therefore should be offered \_ gradually, but in a responsive incremental manner. Once the final agreement is reached, a show of goodwill and amicability is essential to cement the assurance that agreed concessions will actually be made and the companies will be supported in any difficulties they may have with the Old Guard.

The possibility that, once they see what is happening, the Old Guard will start to speed up the supply of drugs through normal processes, rather than see themselves be superceded, did exist. They can be informed as soon as an understanding is reached with the companies what the situation is and reminded of why it had to be like that. It is however inadvisable to use the 'threat' of special measures in an attempt to induce cooperation from the Old Guard because of the time factor. This would present them with an opportunity to delay action, and by spinning out negotiations, they could ensure that the budget is not spent at all. It is safer to present them with a 'fait accompli'.

The analysis of 'direct supply' involved consideration of a number of important factors and brought out major contributions 'to a stage in planning and management hitherto played down'. This is the importance of planned bargaining and negotiation, Furthermore, the importance of adherence to undertakings once agreement is reached, by both parties, irrespective of what transpired during negotiations cannot be overemphasised. In the long term, this will be critical in dealings with a variety of other parties. Most conventional literature

overlooks this activity as perhaps unscientific because there is no set formula to proceed with it.

Through the guidance provided by the above analyses, the Minister was able to make real informed decisions which enable the health services to drastically improve in terms of the drugs and equipment supplies to the needy rural areas. The progression in the other critical area of manpower is viewed below.

(c) The Integration of Military Medics into the Health Services

Whereas the many clinics reopening and being reconstructed had supplies of drugs and equipment flowing, there was no adequate health personnel in the outlying areas to provide the care the population needed. This was the next challenge our attention was drawn to. During the struggle, hundreds of guerillas were trained in the camps and in neighbouring countries to treat the wounded and also to be infiltrated into the country to provide now withdrawn care for the rural population. The minister, as the ZANU secretary for health, had actually trained many of them and was mandated to ensure a speedy integration of these into the service to be deployed to work among the communities they served so well before the ceasefire. In ZAPU, a similar requirement existed, since the armies were being integrated, these trained health cadres had also to be integrated.

At the time of the ceasefire in early 1980, all the guerillas had been confined to assembly points awaiting integration into one army under the Ministry of Defence. This ministry was headed by the Prime Minister. The former guerillas' salary was being paid from it, which meant that for those who were to be moved into the health services, there would be no additional budgetary burden. Since the Treasury was not expected to object, there did not seem to be any problems of absorbing them.

Problems however arose from the ministry of health and the Medical, Dental and Allied Professions Council. The former saw the move as unacceptable, because those people had not undertaken the training the



ministry provides, so they were unsuitable; the latter insisted on their being registered under the rules of the council. In reality there existed strong establishment resistance to the taking on of the cadres who were considered a serious challenge to the 'status quo' and an attempt to further strengthen the minister's position. Besides, it was argued no one knew how many there were and where they were. Since there was some conflict between ZAPU and ZANU, the two forces might not even agree to release them. The minister's instructions were that the cadres be integrated soonest so that they could be deployed to the needy clinics.

The progression decided on was:

- (a) to list the cadres by name, age, sex, education, length of training and where obtained, field experience and their location,
- (b) to consult with the ministry staff with the view to setting up a working committee to iron-out the problems of integrating,
- (c) to approach the ZANLA and ZIPRA HIGH commands for their release,
- (d) to ensure that their deployment was effected,
- (e) to plan a clearcut long term strategy for their complete absorption in the service including an outline of their careers.

As the person in the minister's office charged with all the above, I had to decide on the best approach, design it and effect it. This required funding, which UNICEF provided for activities (a) to (c) which had to run concurrently. First, however, a small team composed of the most senior from the cadres had to be put together, briefed and

trained. Once that was done at the head office, approaches had to be made to the high commands and the ministry establishment.

The health cadres had to be moved from the ZANLA and ZAPRA forces which were in the process of being gradually integrated with the former Rhodesian Security forces. This required the consent of their High Commands despite the fact that their minister had given permission for the exercise to be carried out. Since, for other reasons, the commanders regarded this as a drain on their manpower, they felt they should have been consulted before the decision was made. On negotiating, they were willing to release the health cadres and cooperate with us provided, the exercise would enable those they retained, to be assessed for a level to be applicable to the army as well. This would enable them to overcome problems they were encountering in the Army Health Corps still controlled by the former Rhodesian Security Forces.

From the ministry, the Old Guard supported by the Council, require that the cadres be tested and screened to determine their eligibility. The Old Guard were convinced that these cadres would fail even the most simple of tests for entry into the Medical Assistants grade of employee. The minister on his part was faced with the decision either to 'by-pass' the council and ministry and their requirements and issue a directive, or, comply with some joint procedure to be determined. In a fair test he was confident that the cadres would perform, but he doubted the fairness of both the test and the marking.

In tableau 8.d is shown the first analysis done with the list of players and options open to them, in 1980. The 'current scenario' is that: the Ministry of Defence agree to the release of the medics, Unicef provides the funds for the exercise, the Minister of Health organises for the list to be prepared, the Old Guard requires that they be given a normal test, but the ZIPRA and ZANLA high commands are not agreed to release them. There is a different view however, of this scenario between the Minister of Health (Minister) and the Old Guard and the Council (Old Guard). The Minister's view is that an adequate number would pass if there is fairness throughout and the Old Guard believes that all would fail even if the test is fair (normal) or adjusted.

Although willing to have the cadres tested, the Minister remained concerned about the test, which had to be written. He felt the cadres had spent years in the war without recourse to theoretical work. They would be poorly equipped to sit an examination, besides, they had no time to prepare for it. There was a need for a 'fall-back option', if he was to get many of the cadres to go through. There was therefore a need for the provision of a 'practical interview' for those sufficiently experienced who failed to do well in the written examination. This position however was not to be disclosed to the examining sub-committee which comprised of a team member from the 'accepted as fully qualified cadres', and three others from the Ministry's pool of nurse tutors. This scenario is shown in tableau 8.e.



TABLEAU 8.d

The following was the list of players and options as we saw them in August 1980.

<u>ZIPRA:</u>	Release medics	0
<u>MINISTRY OF DEFENCE:</u>	Release medics	1
<u>UNICEF:</u>	PROVIDE FUNDS	1
<u>MINISTER:</u>	Organise cadres for registration	1
<u>ZANLA:</u>	Release medics	0
<u>OLD GUARD:</u>	Require normal tests	1

Adequate
Number passes
ZANU 50-50
View

Convinced
100% failure
Old Guard
View

TABLEAU 8.e

<u>ZIPRA:</u>	Release medics	0	1
<u>MINISTRY OF DEFENCE:</u>	Release medics	1	1
<u>UNICEF:</u>	PROVIDE FUNDS	1	1
<u>MINISTER:</u>	By-pass OLD GUARD (If most failed)	0	1
	By-pass immediately	0	0
<u>ZANLA:</u>	Release medics	0	1
<u>OLD GUARD:</u>	Require normal tests	1	1

Minister Reserve of
'Practical Interview'
if exam is not satis-
factory to Minister

Strategy to
by-pass if
nearly all
cadres failed

The first column reflects the minister's strategy to resort to the 'practical interview' if the examination is not satisfactory to him. He has two options, 'to by-pass' Old Guard if nearly all cadres failed or to by-pass immediately. With the high commands persuaded to agree to the exercise, their 'no' options became 'yes' which left the analysis to concentrate on the Minister and the Old Guard. The game that was going on between these two players is reflected in the model 8.1(ii).

The Minister prefers not to 'by-pass' the Old Guard when and if they agree to take account of his objection. This would enable him to avoid the Old Guard claiming that the cadres were not competent as shown by his by-passing the screening and testing even though this was adjusted. By-passing would also not be preferred by him because he was confident of their performance under fair conditions. The Old Guard's preference is 'not to adjust' and for the Minister 'not to by-pass'. The strategic diagram 8.viii reflects these moves.

This initial preliminary analysis clearly oversimplified a complex situation. A lot of political repercussions and far reaching consequences were hidden here. It became necessary to view the Minister and the Old Guard's games under two discernible views \_ The pessimistic view and the optimistic view.

The Old Guard, it was observed above, believed the cadres would fail anyway even if they gave them an adjusted test. They were therefore prepared to give them that, than be by-passed. This represents the Minister's pessimistic view hence his intention to by-pass immediately. For the Old Guard, the move to adjusted test standards is

The game which was going on can be further shown as:

Model 8.1(ii)

		OLD GUARD	
		NOT	ADJUST TEST STANDARDS
<u>MINISTER</u>	BY-PASS	1, 1	1, 1
	NOT	2, 3	3, 2

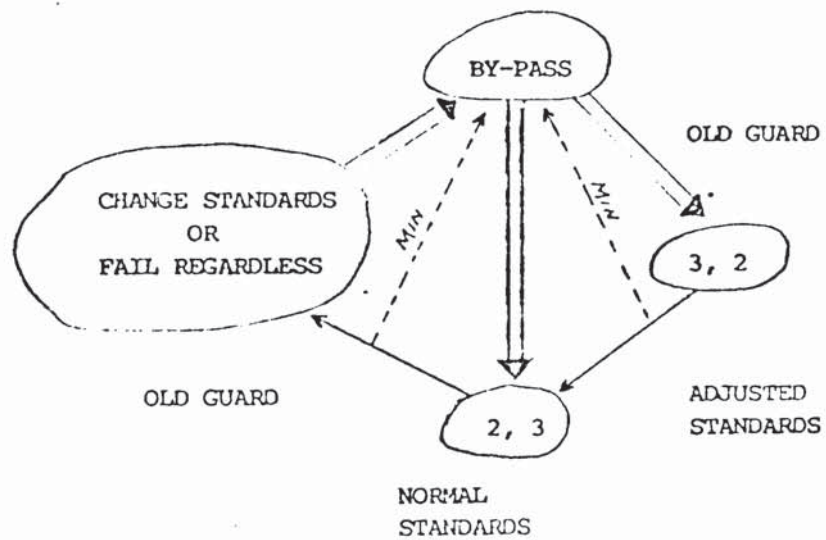
The Minister prefers not to 'by-pass the Old Guard when they adjust the test standards to take account of above observations. This enables him to avoid the Old Guard claiming that the cadres are useless that is why he had to by-pass us even though they failed after we adjusted. He does not prefer by-passing, in any case because we felt the cadres would get through.'

The Old Guard of course prefer that they do not adjust the test and the Minister does not by-pass them. They are convinced the cadres will fail!



The preliminary analysis done can be presented in the following strategic diagram.

STRATEGIC DIAGRAM 8.viii



a guaranteed improvement. But this was overshadowed by the possibility of the Ministers intervention which would lead to the 'by-pass'. This situation is reflected in the model 8.1 (iii).

It can be viewed from the model that action B seemed to be most preferred by the Minister. If he were to adopt that line, his argument would be that the revolutionary cadres should not be tested under a body that represents the very system the government fought to change. Option A would weaken him considerably because it advocates by-passing the Old Guard despite their toning down the test considerably. They would argue that this provided sufficient proof of the incompetency of these cadres. This would amount to an appeal over and above the Minister and government's heads to the people that here were politicians keen to expose them to malpractices of untrained staff. The political consequences could cost him the Prime Minister's support.

The question of what could happen, if he pursued an optimistic view was posed. This is the view that the cadres would pass or at least a good number of them would. The options and preferences open to him are shown in model 8.1(iv). The interpretation of option A would be that the Minister would prefer that the Old Guard not take it upon themselves to place the cadres once it is established that they indeed are capable. There would certainly be no loss on his part if he does not by-pass when the cadres pass the unadjusted test \_ option C. Clearly by-passing immediately would only benefit the Old Guard \_ option B.

Model 8.1(iii)

PESSIMISTIC VIEW  
OLD GUARD

<u>MINISTER</u>	NO TEST ADJUSTMENT			ADJUST TEST STANDARD	
A - BY-PASS (IF)	3,	4	FAILURE	4,	3
B - BY-PASS NOW	5,	2	NO TEST	5,	2
C - NOT BY-PASS	1,	6	NO MEDICS	2,	5

B seemed the most preferred by the Minister to all intends and purposes. If he adopts that line, he can argue that he is refusing to have his revolutionary cadres tested under a body which is archaic and part of 'the system' we want to change. The values upheld by the old approach are in no way acceptable or present in our people oriented cadres. The cadres are change-agents, not conformists! Option A would weaken him considerably because it advocates by-passing the Old Guard after they have given the Cadres a test which is toned down.






We then posed the question as to what the Minister could have done if he continued to take the optimistic view? This is the view that the cadres would pass or at least that some of them have high standards.

MODEL 8.1(iv)

THE OPTIMISTIC VIEW

OLD GUARD

MINISTER

	ADJUSTED STD.			NOT ADJUSTED		STDS.
A - 	4,	2	MEDICS PASSED	3,		1
B - 	2,	3	BY-PASS NOW	2,		3
C - 	4,	2	MEDICS PASSED	3,		1

The interpretation for A would be that the Minister would prefer that the Old Guard not take it upon themselves to place the Cadres once it has been demonstrated that they are indeed capable. There will however be no loss in not by-passing when the Cadres pass the unadjusted test - C. Clearly, by-passing now would only benefit the Old Guard - B.

What emerged from the analysis was a situation whereby both the Minister and the Old Guard preferred the same move but for divergent reasons. The Old Guard believes that these cadres were so crudely trained that would not pass a test no matter how adjusted. They therefore discounted their first intention to set what might be generalised as a 'drastic test' in favour of an adjusted one or a normal one. This they were convinced would put a final stop to the cadres issue and discredit the Minister. They therefore gave wide publicity to the fairness of the test and how it was organised. The Minister on his part was confident that the cadres would perform well since we had organised the whole process with a determination to ensure fairness. Besides, he had recourse to other as yet undisclosed measures. He therefore gave his consent and a willingness to co-operate. At least this attempt was not as controversial as the immediate by-pass alternative.

With regard to the deployment, we had developed a strategy to have those who scored 50% of the pass mark and above to be immediately registrable and deployed to clinics and new Rural Health Centres. Those who scored 40 to 49 per cent to be immediately deployed under the supervision of registered medical assistants and to undergo a six-month training course. Those who got 39% and below to be immediately deployed under supervision and to later undertake full training. The question of non-integration was therefore obviated. As a result, 2000 military medics were tested, screened and deployed as health services staff. The boost to the provision of care, despite other functional problems which would require further planning and management, is clearly significant.

The above analyses were carried out in an attempt to cope with short term requirements for care as well as establishing the basis for more long term policy and programmes. Primary health care's acceptance as the appropriate approach for our situation required that we identify certain priority programmes. The nature of our diseases as discussed in earlier chapters was such that these priorities and programmes be mainly preventive, promotive and rehabilitative. This would not imply that curative services would be neglected, since under PHC, an efficient referral and supervisory structure is a necessity if success is to be achieved.

The priority programmes, which emphasised rural provision strengthening were therefore summarised as:

1. Decentralisation and organisational restructuring.
2. Static facilities repairs, reconstruction, reopening and development.
3. Communicable diseases control programmes restarting tuberculosis, leprosy, malaria and schistosomiasis.
4. Maternal and Child Health programmes development \_ EPI, nutrition, Family Planning and Child Spacing.
5. Environmental health Programmes.
6. Manpower development programme.
7. Supply and maintenance of medical equipment.
8. Drug production control and distribution programme.
9. Health education.
10. Dental care.
11. Laboratory services \_ research and support services.



The implementation units within the restructured divisions roughly reflected the above programmes, as did the budgetary allocation increases. As expressed throughout this study the above priority programmes were drawn up with the equity objective uppermost in our minds. These reflected the aspirations of those who fought the injustices that existed in health care and those who took it upon themselves to design ways to speed-up services improvement.

It is the view here that suffice it to state the above. Any attempt to delve into each one of the programmes individually would call for another study of this magnitude. Since the underlying causes that made them necessary and the process that lead to their effective development and implementation were the subjects of preceeding chapters, these are listed here for completeness.

#### CONCLUSION

What these sections have attempted to highlight is that, real world problems in the health care sector as in any other sector are not clearcut and straightforward, more often than not, they are 'messy' (Huxham and Edwards, 1981.) At the other extreme, one might not even realise that they exist. By their very political nature, game theoretic decision problems therefore tend to be 'unsolvable'. What then one is doing as change agent is analysing choices which are not already existent but whose occurrence you consider possible. The decision maker's outcomes depend on other players' actions and reactions. By nature, the decision makers preferences conflict, therefore what the analysis of options technique offers is predictions

of stability of various possible outcomes in a given situation. It actually goes further and explains, analyses and predicts stability in a conflictual decision situation irrespective of the adversaries. Having done that however, it does not actually recommend or prescribe a specific course of action. That remains a decision maker's prerogative after he has been given an explanation of the predicament he faces.

Where one is, however, in the actual position to make decisions or to actively advise in planning and management, the knowledge and use of the technique improves the quality of the decisions made considerably. Had the above analysis not been made, serious blunders could have been made in the planning and management for health for development in Zimbabwe. As it turned out, good programmes were developed and are being implemented there as direct outcomes of the earlier analyses and decisions based on them.

In the final chapter, conclusions from the whole study are shown and whatever lessons were learnt are listed. It is hoped that in the same manner that Zimbabwe's specific situation and experiences benefitted from the study approach, other countries with comparable conditions could also benefit.

## CHAPTER IX

### CONCLUSION

In this study, I have attempted, through an empirico-historical approach, to determine what lay at the root of Zimbabwe's health problems. One has, by a systematic analysis of the broader issues that brought about and sustained under-development, attempted to situate Zimbabwe in the wider world economic system. This was done with the view to establishing that Zimbabwe is not a unique case. The conclusion is drawn therefore that the forces that interacted therein and created conditions for the flourishing of ill-health (underdevelopment) are universal. By undertaking an indepth study of the mode of interaction of these identified forces and their agents in Zimbabwe, one attempts to provide a mode of progression to follow if the extent and underlying basis of ill-health in a country is to be determined.

The multi-sectoral and interdisciplinary nature of the causes of ill-health was demonstrated and the proposition made that any solution to these conditions has to be intersectoral, multidisciplinary, comprehensive and wholistic, within a conducive political and socio-economic framework that is community based and supported; and that emphasises man and indeed the whole of humanity, i.e. human advancement.

Through viewing the indigenous population's reactions at various points in time to a variety of measures with health impacts, one has



enabled the determination of possible solution paths. More importantly, I suggest in the study that health indeed can be an 'entry-point' if not a 'potent lever' to development (human development); through showing how inextricably linked the underlying causes of ill-health are to factors that constitute or bring about underdevelopment. At the forefront of this, it is proposed throughout, is the central role of the exercise of political power and who controls it, as the determinant of the distribution of economic power and social say and the resultant health status. The shifts in the distribution of these over time are reflective of changes in political say as shown in the particular case of Zimbabwe.

Whereas the size of a country's resources under conditions of equity would determine to a large extent the health status of the population therein, it is shown in this study that; inequitable distribution of existing sizeable resources, a result of deliberate political policy, led to the deplorable state of ill-health of the oppressed majority population in Zimbabwe prior to independence. Redistributive measures, politically motivated and directed, are proposed as a necessary priority in the development strategy proposed. Conventional modes of analysis and planning are shown to be deficient to effect these. Foremost is their inability to break into smaller analytical frameworks, to explain 'political' complexity at different levels of decision making, that dynamically complement the main thrust of the analysis.

One has further shown in the study, the deficiencies of existing frameworks or systems of analysis in enabling sector planners to look

ahead and plan for the future under conditions of conflict. Finally, the proposition is made that the analysis of options as a technique of metagames, offers the most viable approach to planners and decision makers in dynamic conflictual situations. With conflict shown to be endemic in organisations, the approach is a necessary tool of management. Through viewing its actual application in Zimbabwe over time, an attempt is made to show its strengths and applicability in countries with similar conditions. As a tool of management, it has been proposed in the study that analysis of options requires that both subjective and objective valuation be equally weighted in decision situations. In fact, decision makers act on the basis of their subjective game which is the real game for them in decision situations.

What statements can one make on the feasibility of the dissemination of the technique?

Unlike conventional analytical methods of planning which assume convergence in decision or planning situations, this technique recognises that conflict is endemic in decision or planning situations \_ i.e. in all organisations irrespective of size. This is mainly because there are differences in the way players in a decision problem within an organisation view objectives, perceive problems and differences in their value systems. Any plans or decisions made are a result of bargaining and negotiation. Which way they go in the end, is dependent on the individuals participating in the decision situation. The technique allows one; to organise available information better, to identify new information, to work out possible actions and reactions

of other players to his own and other players actions. The ability to recognise one's options and to determine one's preferences before the process, enables one to make preparations and to be ready to adopt courses of action one does not prefer so as to establish the other players in the game's positions- i.e. their options, preferences, etc. Were decision problems straightforward, with total information, then rational choice would be easy to make so that there would not be any need for techniques. But the real world situation is different, people hide their own preferences for fear that knowledge of these by other player in the decision situation would disadvantage them in negotiation and bargaining. Were it possible for all players to show all their options and preferences, then of course the quality of decisions made would be that much higher and total pay-offs bigger for all the players. Objectives in decisions situations in organisations do conflict, hence the need for techniques like analysis of options. Though endemic in organisations, not all conflict is undesirable. Through the process of its resolution the quality of decisions made is enhanced and the performance of the organisation itself improved.

Through the application of sensitivity testing, an important element in analysis of options, changes which occur in the course of the process of analysis are taken into account as the game progresses. As stated in Chapter VII, the game is a time-path of events. It is continuous therefore options are reviewed, indeed they have to be; for any changes or variations which occur whether external or internal to the players in the decision situation. It is essentially because the technique attempts to view what is probably most likely to be done rather than what ought to be done that it holds a lot of potential for



decision makers. Through assessing factors that influence the decision maker's actual behaviour, it closes the gap between what should be done and what is done. By using it to develop a plan based on stability of outcomes analysed from behavioural patterns, decision makers at whatever level improve and bring planning more in line with attainable objectives. The decision-makers, by disregarding unstable outcomes, can now spend more time assessing those options most likely to bring about the desired state. On that basis, the technique questions the validity of optimal solution search. Its progression, as demonstrated in the study, demands that the wider system effects be included but only in the assessment of perceived outcomes. It therefore rejects the comprehensive rational approach's insistence that all alternatives be explored with complete information, as a waste of time and a costly endeavour to no avail.

#### Problems of the Methodology Arising from Experience.

By its very nature, metagame requires that there be some exclusion of elements that create what is termed 'conflict within conflict'. This in our experience required that we exclude ZAFU and UANC players from the task force. Whereas it is true to say that this eliminates the danger of peripheral conflict which detracts from the essence of the analysis, it is possible that this may lead to consideration of consensus-based options. This holds the danger of propagating conformist attitudes in negotiation for fear of exclusion from the process before it gets underway. Perhaps comparative studies could be done to view the quality of decisions that are arrived at under both conditions.

The game also has as its key elements agreement of some sort to discuss and find a solution among a group of senior management staff in the same organisation. It assumes a willingness to change some state of affairs if seen to be necessary. Does this actually occur in practice within organisation? Would senior management genuinely pursue an option that guarantees changing the status quo? In organisations like Ministries of Health, the practical experiences seemed to point to the contrary: pursuing options that retain the status quo but change the person in position and replace with another more acceptable one. This may be because senior staff do not have occasion to consider, in an impartial, unbiased non-parochial manner, the organisational objectives. Can one then be justified in stating that departmentalisation makes senior staff rigid, selfish, narrow minded and inflexible? Or is the issue really professionalism versus managerialism? This may be brought out from the persistence of the differences in perception of health care as opposed to medical care; between the physicians and the other disciplines in health care. With these fundamental differences in existence, perhaps our stable outcomes in planning are not so stable after all! Further research would help throw more light on this area.

What other areas of further research?

A lot may still need to be done to perfect this technique, more relevantly, more needs to be done to enable decision makers at lower ranks, within organisations, to utilise it. From a public sector perspective, more community participation and involvement means that ordinary people have to make more decisions more frequently. How can

the technique be taught to lesser trained frontline personnel, so that they can act as analysts in these types of situations? Can it be further simplified for application at the community level where it would be of tremendous benefit in helping them in making choices on hundreds of daily decisions? A breakthrough in that regard would be a genuine first step in transforming the concept of 'bottom-up' planning and community involvement in management, into reality.



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