

The copyright of this thesis rests with the University of Cape Town. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

**‘STATE FAILURE’ IN PROVISION OF EDUCATION AND
HEALTH SERVICES IN ZIMBABWE: ADJUSTMENTS,
ADAPTATIONS AND EVOLVING COPING STRATEGIES OF
RURAL COMMUNITIES, 2000-2007.**

Thesis presented for the degree of

DOCTOR OF PHILOSOPHY

Department of Political Studies

UNIVERSITY OF CAPE TOWN

by

Norbert Musekiwa



Supervised by

Professor Robert Schrire



February 2010

Abstract

The study is an analysis of how two rural communities in Zimbabwe adapted and responded to the decline in health and basic education services between 2000 and 2007. From 2000, Zimbabwe faced socioeconomic and political challenges that have been characterised as the 'Zimbabwean crisis'. The state became unable or unwilling to provide adequate education and health services to the majority of its citizens. The study sought to determine the nature and extent of the emerging coping strategies to a decline in the state service delivery. Hirschman's analysis of exit, voice and loyalty influenced the theoretical framework guiding the study. The reformulated framework incorporates three types of exit, three types of voice, three types of direct action, two types of loyalty, and other alternative options such as apathy and spiritualism. The methodological framework entailed a case study approach of two rural communities in Zimbabwe. The study purposely selected Maotsa and Shumba communities because of their individuality and diversity in terms of geography, socioeconomic conditions and the range of health and education services provided. Data gathering involved conducting semi-structured interviews and focus group discussions in the two communities between July 2007 and June 2008. The study employed the membership categorization device to analyse data from the interviews. The responses were also post coded and analysed with Statistical Package for Social Scientists version 16. The statistical analysis complemented the qualitative analysis.

The study established that communities and individuals responded to the decline of public services through a multiple of strategies. The prominent responses included exit, voice, direct action and a sense of hopelessness and apathy all occurring in multiple variants. In the face of declining public services, the communities responded by going beyond the exercise of voice in the original Hirschman formation of complaining and protesting to collectively cooperating or individually acting to provide the public goods in place of those previously provided by the state. Unlike traditional voice in which consumers seek corrective action by others, Shumba and Maotsa community restored the public services through voluntary local contributions of labour, money and materials. Arising from previous failures at cooperative effort, the Shumba community was less successful at collective action. Due to increased poverty incidence, the alternative of producing public goods locally was not enduring and the communities invariably sought to leverage external donor support. Shumba community was more successful in attracting external support for community projects.

Exit in three forms was a common response to the decline in public service delivery by the state. In Maotsa and Shumba, community members responded to the decline in the quality of services in education by transferring learners to schools within the community that were perceived as performing better. To varying degrees, the communities accessed health services in both the private sector and public sector outside their areas. Outmigration became a common strategy of coping with a decline in health and education services. In both Maotsa and Shumba, remittances from the diaspora were a significant source of family income used to access among other necessities, health and education services. Despite being an effective individual response to the decline in state

provided services, outmigration was not an effective response to the failure of public policy. Indeed, outmigration impoverished the communities exited as it deprived them of the vital skills of medical and education professionals.

In their responses to inadequate public services, the communities exhibited a high degree of resilience, ingenuity and adaptability in face of seemingly insuperable obstacles. Patients compensated for the failure of the state by seeking treatment from private enterprise, self-medication and greater reliance on spiritual healing. The clinics established mechanisms for sharing drugs in short supply through a complex method of barter exchange. In education, teachers improvised learning aids to overcome stationery shortages. Learners compensated for the teachers' absences by organizing themselves into study groups. Health and education personnel were engaged in moonlighting as a strategy of broadening their income bases.

Some members of the community failed to respond effectively to challenges brought by the decline in public services and resorted to perverse coping strategies. In education, the most prevalent perverse coping strategy was the withdrawal of learners from school. In health, patients delayed or never sought medical attention when it was required and disposed of assets to pay for health costs. Patients prescribed medicines often purchased a portion of the medicine. In general, citizens adapted to living with much less or no service at all.

University Of Cape Town

Plagiarism Declaration

I, Norbert Musekiwa declare that the work that gave rise to this thesis, is my own original work, and that, where work from other scholars is used, it has been clearly referenced. This work has neither been nor is being submitted concurrently in any institution for any degree.

Signed:

Norbert Musekiwa

Date:

University Of Cape Town

Acknowledgements

I thank my supervisor, Professor Robert Schrire, for his diligent and able guidance. I acknowledge with sincerest gratitude, the fellowship grant from the University Science, Humanities, Law and Engineering Partnerships in Africa (USHEPiA) programme that covered the costs for my tuition, board at University of Cape Town (UCT) and fieldwork. I owe gratitude to the UCT in partnership with the Sigrid Rausing Trust for the Eric Abraham Academic Visitorship to the University of Cape Town.

I am particularly thankful to Nan Warner, Dr Loveness Kaunda, Masego Mogodu and Norma Derby of the International Academic Programme Office for providing me with a home away from home. Professor Schrire and ‘mother’ Nan Warner were helpful in securing my family when in 2008, we responded to the state implosion in Zimbabwe by immigrating to the Republic of South Africa.

To Daniel Chihombori of the University of Zimbabwe International Office, I am grateful for among many favours, alerting me of the existence of the USHEPiA programme in the first instance. I thank my employer, the University of Zimbabwe for granting me leave to undertake the study. I thank the women in the Political Studies Department at the University of Cape Town, Joanne Polzin, Rosalind Maree, Waheida Gajjar, Phumla Msutu and Lee-Anne Wolmerrans for their friendliness and efficient service.

I am appreciative to Mai Chonyera of Wadzanai Training Center, Goromonzi District for her support, recommendations and introductions to the Shumba community. The initial entry into the Shumba community was only possible through her recommendations. Introductions by staff of the Zimbabwe Women’s Bureau at both the national office and Makumbi sub offices were helpful in establishing a trusting relationship with the Shumba community.

Data collection was possible by the thorough and able assistance of the Research Assistants, Norbert Gaha and Blazio Mkozho. I gratefully acknowledge the cooperation,

introductions and unrelenting support from the councillor for Shumba ward, Brighton Sanyika. Headmen Shumba and Maotsa granted me the clearance to undertake the research in their communities when the volatile political environment preceding the 2008 harmonized presidential and general elections advised otherwise. I am thankful for their trust and indulgence. I remain forever beholden to all respondents from Shumba and Maotsa for the friendliness and hospitality and for sharing with me their coping strategies. Special thanks are also due to the civil servants at various levels who cooperated in this research.

I am grateful for the support I received from friends: Dr. David Mandiyanike, Glen Mpani, Dr. Gideon Zhou, Ashella Tshedza Ndhlovu and Dr. Ramson Mbetu. Their friendship, assurances and company made the load much lighter. To USHEPiA Fellows, thank you for the friendly company and for remaining a constant source of inspiration and especially reminding me that the unusual experiences were not unique but indeed common.

I salute my parents, Mawande and Inviolata Musekiwa, and remain forever grateful for their sacrifices to provide me with a decent education when they had extremely limited resources at their disposal. My academic endeavours were also bearable because of the support I got from my siblings.

I thank my wife, Ivy *vaChihera*, for her support and encouragement over the years. I compliment her for the endurance and taking care of our 'boys' during my long absences. I hold her in high esteem for the ability to cater for the family, unaided, in the most inauspicious conditions when the state was failing to deliver essential public services. Lastly, I appreciate my sons, Takudzwa and Mawande Norbert Jr. for their active support and dignified demeanor in accepting to do with less than they would otherwise deserve had I not embarked on this scholarly venture.

Abbreviations and Acronyms

AIDS	acquired immunodeficiency syndrome
AIPPA	Access to Information and Protection of Privacy Act
ART	anti-retroviral therapy
ARV	anti-retroviral
BCG	Bacillus calmette-Guerin
BSAC	British South Africa Company
CADEC	Catholic Development Commission
CD4	Cluster of differentiation 4
CPI	Consumer Price Index
CSO	Central Statistical Office- Government of Zimbabwe
DPT	Diphtheria-Perstussis-Tetanus
EPI	Expanded Programme for Immunisation
ESAP	Economic Structural Adjustment Programme
FBO	faith-based organisation
FGD	focus group discussion
FPL	Food Poverty Line
GoZ	Government of Zimbabwe
HIV	human immuno virus
HCW	health community worker
IMF	International Monetary Fund
MCAZ	Medicines Control Authority of Zimbabwe
MDC	Movement for Democratic Change
MDG	Millennium Development Goal
MLG,PWNH	Ministry of Local Government, Public Works and National Housing
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
OI	opportunistic infections
PRF	Poverty Reduction Forum- University of Zimbabwe
PPTCT	prevention of parent to child transmission

PTUZ	Progressive Teachers' Union of Zimbabwe
POSA	Public Order and Security Act
RBZ	Reserve Bank of Zimbabwe
RDC	Rural District Council
SDA	school development association
SDC	school development committee
SPSS	Statistical Package for Social Scientists
TCPL	Total Consumption Poverty Line
UCT	University of Cape Town
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USHEPiA	University Science, Humanities and Engineering Partnership in Africa
VIDCO	village development committee
VHW	village health worker
WADCO	ward development committee
Wenela	Witwatersrand Native Labour Association
ZANU PF	Zimbabwe African National Union, Patriotic Front
ZESA	Zimbabwe Electricity Supply Authority
ZIMA	Zimbabwe Medical Association
ZIMSEC	Zimbabwe Schools Examination Council
ZIMTA	Zimbabwe Teachers' Association
ZNLWVA	Zimbabwe National Liberation War Veterans Association
Z\$	Zimbabwean dollar
ZTV	Zimbabwe Television

Contents

Abstract	i
Plagiarism Declaration	iii
Acknowledgements	iv
Abbreviations and Acronyms	vi
CHAPTER ONE: INTRODUCTION TO STUDY	1
1.0 Introduction	1
1.1 Background to the Problem	3
1.2 Statement of the Problem	4
1.3 Study Aims and Objectives	5
1.4 Importance of the Study and Justification	6
1.5 Delimitations and Limitations	8
1.6 Working Definitions	9
1.7 Content and Form of the Study	10
CHAPTER TWO: THEORETICAL FRAMEWORK	12
2.0 Introduction	12
2.1 Exit	13
2.2 Voice	16
2.3 Direct Action	18
2.4 Passivity, Apathy and Helplessness	20
2.5 Spiritualism and Tradition	21
2.6 Loyalty	22
2.7 Political Patronage	24
2.8 Interaction of Response Options	25
2.9 Conclusion	25
CHAPTER THREE: METHODOLOGICAL ISSUES AND STUDY AREAS	27
3.0 Introduction	27
3.1 Study Areas	30
3.2 Sample and Sampling Procedures	37
3.3 Methods of Data Generation	38
3.4 Analysis of Data	50
3.5 Ethical Considerations	52
3.6 Risks and Assumptions	53
3.7 Conclusion	54
CHAPTER FOUR: LITERATURE REVIEW	57
4.0 Introduction	57
4.1 Discourses on State Provision of Public Services	57
4.2 Discourses on State Delivery Failures	66
4.3 Coping Strategies	74
4.4 How Zimbabweans Coped with Previous Crises	78
4.5 Power, Class and Interest	82
4.6 Conclusion	85

CHAPTER FIVE: CONTEXTUALISING THE POLITICAL DEVELOPMENTS AND ECONOMIC DECLINE IN ZIMBABWE	87
5.1 Introduction.....	87
5.2 Geography, Economy and People.....	90
5.3 Brief Overview of Pre-independence Zimbabwe (1859-1979).	92
5.4 A Decade of Expansion in Health and Education Services (1980-1989)	96
5.5 A Decade of Liberalisation (1990-1999)	101
5.6 An Era of Transition to Democracy, Economic Decline and State Service Delivery Failure (2000-2007)	106
5.7 Conclusion	112
CHAPTER SIX: MAOTSA, EDUCATION AND HEALTH FINDINGS	115
6.0 Introduction.....	115
6.1 Education	116
6.1.1 From State Reliance to State Avoidance.....	116
6.1.2 Teacher Based Strategies	119
6.1.3 Internal Provider Exit.....	122
6.1.4 Leveraging External Support	123
6.1.5 Local Communal Direct Action	125
6.1.6 Political Patronage.....	128
6.1.7 Helplessness and Apathy.....	130
6.2 Health.....	131
6.2.1 Collapse of the Primary Health Delivery System 2000-7	133
6.2.2 Exit	134
6.2.3 Communal Direct Action	135
6.2.4 Leveraging External Support for Direct Action.....	136
6.2.5 Reordering of Health Service Provision.....	137
6.2.6 Self Medication	139
6.2.7 Traditional Medicines and Herbs	139
6.2.8 Perverse Coping	140
6.2.9 Helplessness, Apathy and Substitution	141
6.3 Cross Cutting Responses.....	142
6.3.1 Migration.....	142
6.3.2 Collective Voice via Electoral Process	148
6.3.3 Broadening of the Civil Servant Asset Base	149
6.4 Conclusion	151
CHAPTER SEVEN: SHUMBA, EDUCATION AND HEALTH FINDINGS.....	153
7.0 Introduction.....	153
7.1 Education	153
7.1.1 State Reliance to State Avoidance	153
7.1.2 Direct Action	155
7.1.3 Exit.....	157
7.1.4 Teacher Based Strategies	159
7.1.5 Leveraging External Support	161

7.1.6	Political Patronage.....	166
7.1.7	Voice	166
7.1.8	Helplessness and Apathy.....	167
7.2	Health.....	169
7.2.1	Collapse of the Primary Health Delivery System 2000-7	170
7.2.2	Local Communal Direct Action	172
7.2.3	Leveraging External Support and the Erosion of State Influence	174
7.2.4	Reordering of Health Service Provision.....	175
7.2.5	Internal Provider and Public Exit.....	176
7.2.6	Dual Access of Public and Private Health Services.....	178
7.2.7	Self Medication	180
7.2.8	Religious Appeal/Spiritualism	181
7.2.9	Traditional Medicines and Herbs	183
7.2.10	Perverse Coping	185
7.2.11	Helplessness, Apathy and Substitution	187
7.3	Cross Cutting Responses.....	187
7.3.1	Migration.....	187
7.3.2	Collective Voice via Electoral Process	187
7.4	Conclusion	189

CHAPTER EIGHT: MAOTSA AND SHUMBA IN COMPARATIVE PERSPECTIVE

	193
8.0	Introduction.....	193
8.1	Education	194
8.1.1	From State Reliance to State Avoidance.....	194
8.1.2	Communal Direct Action	196
8.1.3	Leveraging External Support for Direct Action.....	200
8.1.4	Teacher Based Strategies as Direct Action	201
8.1.5	Voice	202
8.1.6	Exit.....	206
8.1.7	Helplessness and Apathy.....	206
8.2	Health.....	208
8.2.1	Collapse of the Primary Health Delivery System 2000-7	209
8.2.2	Local Communal Action	211
8.2.3	Externally Supported Direct Action.....	213
8.2.4	Reordering of Health Service Provision as Direct Action	214
8.2.5	Self Medication as Individual Direct Action.....	214
8.2.7	Exit.....	215
8.2.8	Voice	216
8.2.9	Religious Appeal and Traditional Medicine	217
8.2.10	Helplessness, Substitution and Improvisation.....	219
8.3	Cross Cutting Issues.....	220
8.3.1	Migration.....	220
8.3.2	Collective Voice via the Electoral Process	224
8.3.3	Structures for Participation.....	225
8.3.4	Broadening of Civil Servant Asset Base	226

8.4	Conclusion	226
CHAPTER NINE: CONCLUSIONS		228
9.1	The Study	228
9.2	The dynamics of coping over time and space	229
9.3	Future Research Prospects	237
References		238
Appendix A	Informed Consent	261
Appendix B	Clearance Letter from Department Social Welfare	263
Appendix C	Clearance Letter from Ministry of Education, Sport and Culture	264
Appendix D	Interview Guide for Teachers' Associations	265
Appendix E	Interview Guide for Ministry of Health and Child Welfare Staff	266
Appendix F	Community Profile and Focus Group Discussion Guide	267
Appendix G	Interview Guide for Households.....	268
Appendix H	Coded Interview Guide for Households	271
Appendix I	National Respondents' Statistics	277
Appendix J	Maotsa Statistics on Respondents.....	278
Appendix K	Shumba Statistics on Respondents	279
Appendix L	Freedom House Country Scores for 2006	280

List of Tables

Table 3.1:	Distribution of Health and Education Facilities in Shumba and Maotsa...	37
Table 3.2:	National Summary of Respondents.....	38
Table 4.1:	Registration of Preschools for 1995, 2000 to 2005.....	61
Table 4.2:	Number of Primary Schools by Responsible Authority and Province 2004.....	62
Table 4.3:	Number of Secondary Schools by School Authority and Province, 2004.....	63
Table 4.4:	Distribution of Health Facilities Levels and Province.....	65
Table 4.5	Failed States Index Rankings for Zimbabwe, 2005 to 2008.....	72
Table 5.1:	Zimbabwe Inflation Rates, 2000-2007.....	110
Table 8.1	Respondents Ratings of Quality of Education Services.....	194
Table 8.2	Respondents Assessment of Quality of Health Infrastructure.....	209
Table 8.3	Respondents Accessing Private Medical Services.....	215
Table 8.4	Respondents Choosing Not to Seek Medical Attention.....	219

List of Maps

Map 1: Zimbabwe- Location of Study Sites.....33
Map 2: Goromonzi-Shumba Schools and Clinic.....34
Map 3: Gutu- Maotsa Schools and Clinic.....36

University Of Cape Town

List of Plates

Plate 1: Methods in Pictures.....56
Plate 2: Education in Pictures.....191
Plate 3: Health in Pictures.....192

University Of Cape Town

CHAPTER ONE: INTRODUCTION TO STUDY

1.0 Introduction

This study is an analysis of how two rural communities in Zimbabwe between 2000 and 2007 responded to the failure by the state to deliver public goods in the key areas of health and basic education. From 2000 to 2007, Zimbabwe experienced a socioeconomic and political crisis resulting in a gradual failure by the state to deliver public services. During this period, the government substantially reduced its funding for social services particularly health and education. Significant gains made in the delivery of social services during the first two decades of independence from 1980 were quickly eroded during periods of decline leading to deficits in the public provision of education and health services. Services in the health and education sectors between 2000 and 2007 declined to become a shadow of their relatively high performance during the first decade of independence.

Against a backdrop of declining state-provided public services, the study sought to establish how rural communities responded to the increasing inability of the state to deliver in the areas of health and education. Specific questions guiding the study were: How did the communities adapt to the decline? What coping and survival strategies evolved? What factors influenced the responses? How did the different response strategies complement or undermine each other?

The theoretical framework guiding the study was adapted from Albert O. Hirschman's 1970 theory of exit, voice and loyalty, in which he explores various options available to customers faced with a declining service quality. The theoretical framework of exit, voice, loyalty, local direct action, apathy and hopelessness developed for this study integrates some of the criticism to Hirschman's concepts with alternative theoretical approaches to analysing community responses into a broader synthesised framework. The emergent theoretical framework postulates that over and above the three forms of exit and three types of voice, communities may respond to a decline in the state service

provision by acting directly to produce the public goods previously provided by the state. Communities can also rationally settle for passivity as the optimal alternative.

The study is significant in that traditionally, studies on failing African states were primarily concerned with the role of the state, how it related with citizens and other states (Bates, 2008; Rotberg 2007; Rotberg 2004; Milliken and Krause 2003; Zartman 1995; Herbst 1990b). This study is a departure from that mainstream state-centric approach as it sought to uncover the societal responses to the actions and inactions of the state. The study provides insights into community responses to the state inability to provide the essential social services. The choice of education and health was based on the assumption that the two sectors are key components to the well-being of communities. The access to health and education influence the political, economic and social well being of a population (GoZ 2006, 152). The level of education and health provision effectively define the human development status (PRF 2003, 37).

The methodological framework entailed a case study approach of two rural communities in Zimbabwe. The study purposefully selected Maotsa and Shumba communities based on their individuality and diversity in terms of geography, socioeconomic factors and the range of health and education services provided. The main unit for data collection and analysis was the community with the individual and household as embedded units. Data collection involved conducting in-depth interviews, focus group discussions (FGDs) and non-participant observation. Data from interviews was analysed qualitatively using the membership categorization analysis framework pioneered by Sacks (1992). The interview responses were also post-coded and further analysed with the aid of the Statistical Package for Social Scientists (SPSS) version 16. Complementing qualitative analysis, the SPSS was restricted to descriptive methods, the creation of frequency tables and cross tabulations.

The next section in this chapter provides a brief background to the provision of health and education in Zimbabwe since independence in 1980. It outlines a background of unequal access to social services by the different racial groups at independence that

government sought to and successfully redressed during the first decade of independence. Chapter One specifies the statement of problem, the study aims and objectives. This Chapter also presents the scope, rationale, significance and limitations of the study. The brief chapter outline of the thesis is presented in the last section of the chapter.

1.1 Background to the Problem

Zimbabwe attained African majority rule from Britain in 1980. The new independent government with socialist orientations inherited an enclave dual economy with a modern industrial sector juxtaposed with the poor rural areas that carried about 80% of the population (GoZ 2004, 11; Kanyenze 2003, 35; PRF 2003, 8). The government sought to address the structural imbalances in the dual economy through socialist informed economic development policies.¹ In that regard, the new government achieved significant progress in the social sectors specifically health and education during the first decade of independence. The involvement of central and local governments, missionaries, non-governmental organisations (NGOs) and external donors played an active role in funding and delivering of services making possible progress in the provision of the social services (Muzondidya 2009, 168).

Despite this progress during the first decade of independence, Zimbabwe from the late 1990s to 2007 experienced macroeconomic and sociopolitical challenges that have been characterised as the “Zimbabwean crisis”. Reduced service delivery became evident and there was growing consensus that the state had become weak, experiencing the most challenging crisis since independence and a possible implosion (Raftopoulos and Mlambo 2009; Raftopoulos 2007; Rotberg 2007; GoZ 2004, 16; Muponde and Primorac 2005; Hough and du Plessis 2004; Hammar, Raftopoulos, and Jensen 2003; Kanyenze 2003, 68). The crisis was symptomatic of the state’s inability or unwillingness to provide the key social services to a majority of its citizens. The decline in the state capacity to

¹ Such policies include among others, Growth with Equity (1981), the Zimbabwe National Transitional Plan (1982-985) and the Zimbabwe First Five Year National Development Plan (1986-90). As argued by Dashwood (1996, 34) the policies adopted by the new government at independence in 1980 were nationalist and socialist-welfarist in nature.

deliver the public services in Zimbabwe was not abrupt but gradual, spanning over a decade.

The first decade of independence witnessed phenomenal quantitative expansion in social services and an accompanying decline in the quality of educational output, whilst the second decade was characterised by stagnation or decline in the school enrolment and the reduced access to health services (Muzondidya 2009, 168; Narman 2003, 150; PRF 2003, 10). The third decade of independence was to see a reduction in government support leading to sharp declines in the quality of service and the gradual collapse of the economy, the public sector in general and the education and health delivery systems in particular.

1.2 Statement of the Problem

The problematic situation was the postcolonial state's failure to continue to deliver social services, particularly health and education, negating the state's earlier commitment to provide them as a means of redressing the colonial racial imbalances in the provision and access to essential services. The issue of how the communities could, in the event of state inability or unwillingness to deliver the public goods, cause the state to improve service delivery or alternatively, generate strategies to access similar services outside framework of the state, remains unresolved.

The Zimbabwean state between 2000 and 2007 faced serious capacity challenges in meeting the key responsibilities of providing legitimate representation and welfare to a majority of its population. Though the state demonstrated formidable capacity to maintain and use the state security agencies to repress dissent, it simultaneously displayed shortcomings in meeting the requirements for public goods that the state had committed to provide in education and health (Worby 2003, 56).

Economic decline in Zimbabwe led to a 'brain drain' that affected particularly the health and education sectors (Tevera and Crush 2003, 7). Between January and April 2007,

4500 teachers left the civil service for South Africa, Botswana, Namibia and Swaziland, a figure much higher than the 5000 who left in the whole of 2006 (Ndlovu 2007)². In April 2007, Zimbabwe had through resignations and emigration lost 42% of its doctors and 34% of its nurses, and had 36 senior doctors in post against an establishment of 145, and only 72 specialist consultants out of an establishment of 189 (Tsiko 2007). By the end of 2007, there were only two paediatric surgeons operating in the public sector and only two specialist pathologists out of the required eight in Zimbabwe (The Herald 22 July 2008; Tsiko 2007). Frequent, threatened and actual collective job actions by the civil service unions for increases in salary and allowances and better working conditions from the beginning of 2006 threatened the collapse of the health and education sectors.

The high inflation and hyperinflation from 2007 resulted in decreased real government revenue and an increased budget deficit. Due to chronic shortages of foreign currency and the sporadic availability of fuel (RBZ 2008a, 21), schools went without essential learning and teaching materials whilst clinics were constantly short of medicines and basic equipment (Bratton, Chikwana and Sithole 2005, 79). The country's sole state-owned electricity company, the Zimbabwe Electricity Supply Authority, from mid 2007 increased load shedding up to twenty hours per day for domestic consumers (Shoriwa 2007). The power outages adversely affected most health centres and education facilities that fed from domestic electricity grids. The Zimbabwe government, by December 2007 was failing to deliver even the barest of key social services.

1.3 Study Aims and Objectives

The aim of the study is to investigate how selected rural communities and households in Zimbabwe from 2000 to 2007 responded to the increasing failure by the state to provide essential health and education services.

The broad question guiding the study was how rural communities in Zimbabwe adapted to and survived the declines in state services in the education and health sectors.

² For discussion on Zimbabwean situation and emigration, see section 4.4 and 8.3.1.

From the broad question emerged four specific questions namely:

- 1 How did communities and households react to the state's failure to provide the essential services in health and education sectors?
- 2 How did communities and households organize and cooperate to meet the public goods deficits in health and education?
- 3 What dynamics (local leadership, economic, and geography) informed the coping strategies?
- 4 How did the different response strategies complement or undermine each other?

1.4 Importance of the Study and Justification

Education and health are key drivers in development hence their dominance in the Millennium Development Goals (MDGs) (World Bank 2003, 2). In fact, of the eight MDGs three refer directly to health matters and a fourth to universal access to education. Education is an important instrument of reproducing and creating a new society (Narman, 2003, 157). Education is also one decisive factor in determining the economic condition of an individual with the less educated being prone to higher incidence of poverty than their educated counterparts (GTZ 1999, 17). Furthermore, education is an influential factor in generating the future income-earning opportunities, long-term birth rates, infant mortality and helps develop the capacities in problem-solving strategies in difficult circumstances (GTZ 1999, 18). Poor health is not only an individual burden but also reduces capabilities of families and retards development as persistent ill-health limits individual and family abilities to 'earn a living, save money for food and essential drugs, in turn creating a vicious cycle of ill health and poverty' (Crowe 2006, 27).

Most studies in postcolonial Africa have concentrated on the state as the dominant and universal unit of political organisation: its structure, its effectiveness, its capacity, and its linkages with non-state actors. As argued by Azarya and Chazan (1998), the approach was correctly based on the assumption that the African state had the capacity to fulfil the expectations of the majority of citizens. The sustained interest in the state was also

informed by the notion that modern states constitute the fundamental building blocks of the world political order (Rotberg 2004, 1). A dysfunction in one constituent component state, therefore, ‘threatens the very foundation of that system’ (Rotberg 2004, 1). Due to linkages among modern states and the role of the state in the contemporary world order, states failing on key public service mandates cease to be just a Hobbesian nightmare to the local inhabitants but pose serious dangers to others by being a source of insecurity (Collier 2007, 3; Williams 2006, 37; Rotberg 2004, 1; Milliken and Krause 2003, 12; Wainwright 2003, 486). The African state is critical because of its omnipresence and omnipotence, dominating the employment market and economic activity (Herbst 1990a, 1).

As a number of African states weaken and fail to provide basic public services (Englebert 2009, 3; Bates 2008; Collier 2007; Rotberg 2007; Williams 2006; Herbst 2004; Zartman 1995), there is the increasing need to investigate the impact of the failure and the responses of the citizens to the actions and inactions of such states. Azarya and Chazan (1998, 133) ably argue that it is equally important to investigate the forms of “disengagement from the state as it is to examine efforts at engagement in the state nexus” and conclude their contribution pointing out that “societal reactions to the state should occupy a more central stage in scholarly work”. Furthermore, “the centrality of the state could no longer be glibly corroborated in practice” (Rothchild and Chazan 1988, ix). This study builds onto a comprehensive study on people-based responses to state failure in Africa that was conducted in the urban context of Kinshasa in the Democratic Republic of Congo (Trefon 2004).

The studies of the decline in state service delivery have been limited, ‘with literature hitherto marked by imprecise definitions and paucity of sharply argued instructive and well delineated cases’ (Rotberg 2004, 31). This study therefore sought to deepen the theoretical understanding of societal responses to failures by the state to deliver public services. The study investigated how ordinary people survived for sustained periods, not only hostile but the increasingly deteriorating macro environments characterised by sharp declines in the Gross Domestic Product (GDP), life expectancy at birth, literacy level,

maternal deaths, and other Human Development Indicators (HDI). The results of the study can potentially inform governments, external support agencies, and civil society on how institutions and policy could be modified to benefit those most vulnerable when states fail to deliver on their key social services mandate. The study will provide a useful addition to the growing literature on state decline and failure in Africa and the coping strategies adopted by communities.

This study differs from previous studies in that most studies on Zimbabwe have investigated the effects of state actions and inactions on society, (Raftopoulos and Mlambo 2009; Rotberg 2007; Hammar *et al* 2003; Herbst 1990a; Stoneman 1989). Bratton *et al* (2005) focused on public opinion assessment of the economic conditions in Zimbabwe and the performance of the political leadership. Other studies have concentrated on specific programmes such as the Economic Structural Adjustment Programme (ESAP) and government operations such as the 2005 Operation Restore Order (*Murambatsvina*), land reform (Bratton and Masunungure 2006; Chisvo 2000; Mwanza 1999; Mupedziswa and Gumbo 1998; Mlambo 1997; Drakakis-Smith 1994) whilst this study focused on societal responses to actions and inactions of the state. The focus was specifically on the community adaptations, adjustments, and evolving survival strategies in the event of public policy failure to provide the essential services in the two sectors of health and education.

1.5 Delimitations and Limitations

The study selected two rural communities in separate administrative provinces with different ecological conditions for data collection. Both communities were wholly communal in terms of land tenure categorisation. Though early symptoms of the service quality decline first became visible in the late 1980s forcing government to embark on a 'Breton Woods' Institutions supported ESAP in the 1990s, the study only covers the period of heightened crisis between 2000 and 2007.

The study concentrated on public goods in the social sectors of health and education and purposefully left out other forms of public goods such as political and civil liberties that

some scholars such as de Mesquita *et al* (2003, 179) have characterised as core public goods. In education, the study is limited to basic education.

Another limitation is that the choice of communal areas for the case studies may mean that the results and conclusions generated may not be generalisable to other land categories such as commercial farming, newly resettled, urban, and mining areas. Additionally, as cautioned by Chazan (1988, 122), society-based approaches to the study of state-society relations are mostly based on micro cases and risk ‘minimising, or ignoring activities emanating from the centre’. One further limitation is that the state delivery capacity decline was a nonlinear and dynamic process that occurred over a long period and so were the adjustments, adaptations and coping strategies. As observed by Rotberg (2007, viii) the failing states presented as case studies were essentially moving targets. This study therefore does not offer a comprehensive picture of the responses to the state decreasing capacity but only captures part of the decline and adaptations at given points in time.

1.6 Working Definitions

Basic education covers the primary and secondary school levels of learning.

Coping involves the individual, household or community making cognitive and behavioural adaptations when confronted with change-producing events.

Exit entails reducing or stopping consumption of a product because the quality has deteriorated. There are three forms of exit: external exit, internal provider exit, and internal public exit.

Household as adapted from the definition used by the Poverty Assessment Study Survey II (GoZ 2006) refers to an individual or group of persons who usually live and eat together, whether or not they are related by blood, marriage or adoption. As argued by Pankhurst (1988, 2), a household may or may not coincide with the economic unit of production.

Local direct action involves the deliberate initiatives by communities, groups and individuals, often with support of external support agents and other non-state actors to create public goods in place of the support the state could no longer provide.

Loyalty is the ‘special attachment’ to an organisation that affects whether an individual’s response options to a declining quality of service. It is not a response alternative but an orientation that influences the trade-off between the response options.

Migration is the movement of people occasioned by economic or other necessity. It is different from travel that involves voluntary movement.

State is a legal entity recognised as such by other states and enjoying monopoly over the exercise of violence in the Weberian sense.

State failure entails the functional inability to deliver the stately duties of security and public order, legitimate representation and welfare. State failure is conceptually different from an advanced form of state collapse (Milliken and Krause 2003, 2).

Strategy implies some executed plan, employed in response to internal and external factors to survive at the same level or attain upward mobility.

Voice is any attempt to change, rather than escape, an objectionable state of affairs, whether through individual or collective action.

1.7 Content and Form of the Study

The thesis is divided into nine chapters. Chapter One introduces the study. It gives a statement of the central issues investigated and an overview of the methodological approach. The objectives and questions raised by the study are also discussed. It further demonstrates how the study links and builds on extant approaches in political studies. Chapter One outlines the scope and limitations of the study.

Chapter Two establishes the theoretical framework that guides the study. Employing Hirschman’s exit, voice and loyalty theory as a point of departure, the Chapter, incorporates elements of local direct action, apathy and helplessness and builds a broader, synthesised framework. Chapter Three presents the methodological issues and introduces the study areas. The procedures followed in selecting the sample cases and respondents are dealt with here. Chapter Three analyses matters related to data collection, data analysis and the guiding ethical considerations.

Chapter Four reviews literature germane to the study and explores literature on the following main themes: the provision of public goods by states, state incapacities and the community coping strategies. Chapter Five provides the context to the study. It establishes the nature of the state capacity before the decline in the state service delivery and the levels of the educational and health services accessed before the economic implosion. The Chapter analyses how the political and economic forces affected state capabilities to deliver public services.

Chapter Six and Seven present thematically, the research findings on education and health for the two cases, Maotsa and Shumba. Chapter Eight is a comparative analysis of the community coping strategies in Maotsa and Shumba. Chapter Nine presents the conclusions and integrates the arguments of the thesis.

All chapters save for Chapter One and Nine have a similar structure outline. Each Chapter opens with an introduction stating the main issues covered, followed by a presentation of the central arguments of the chapter. The chapters end with a conclusion that gives a summation of the central arguments in the chapter.

CHAPTER TWO: THEORETICAL FRAMEWORK

2.0 Introduction

The theoretical framework that guided the study was adapted from Albert O. Hirschman's (1970) analysis of exit, voice and loyalty. To enhance its relevance to the Zimbabwean situation, the study modified Hirschman's framework to accommodate its weaknesses and expanded it in other ways. This study reformulates Hirschman's exit, voice and loyalty framework and postulates: three types of exit, three types of voice, three types of direct action, two types of loyalty, and incorporates other alternative options such as apathy and spiritualism. This chapter briefly outlines an overview of Hirschman's exit, voice and loyalty framework and then develops the enhanced framework, teasing out its various constituent components.

Hirschman (1970) postulates that when citizens face a declining quality of service from a firm, organisation or a state they have two basic response options to express their discontent: they either exit or voice. Exit means that citizens no longer consume the service or good. Voice is an attempt to improve the service by way of complaining, highlighting the lapses and suggesting the corrective measures required to improve the quality of service. The degree of loyalty influences the consumer's choice of either voice or exit. Hirschman's framework provides a powerful and useful tool for analysing community responses to the declining capacity of the state to deliver public goods. However, the framework in its original design was developed to analyse relationships between the private and public sector in industrial economies and has shortfalls when imported wholesome and applied to developing postcolonial states such as Zimbabwe. In the original formation of exit, voice and loyalty, Hirschman concentrates on the market and the public sector interactions in response to the deleterious decline in the quality of service. The framework developed for this study confines itself to responses to the decline in the provision of public services.

2.1 Exit

In broad terms, exit entails stopping consumption of a product because of dissatisfaction with the quality of the public services provided. Exit exists in three types: external exit, internal provider exit, and internal public exit (Campbell, Dowding, and John 2007, 6; Buchanan and Faith 1987, 1023). The external exit dimension involves ‘voting with one’s feet’. It is the physical out-movement from the jurisdiction of one public provider to access services provided by another jurisdiction (Campbell *et al* 2007, 6). External exit takes two forms: migration to another country and relocation to other parts of the country. Access to external exit is not universal but is strongly influenced by the levels of resource endowment. The resource-endowed who possess movable wealth, transferable across borders have the easiest access to external exit through migration whilst the poor communal farmers whose wealth is based in immovable assets encounter problems in accessing exit by way of migration (Hirschman 1978, 98).

In postcolonial states, external exit in the form of out migration is mostly employed by the skilled and educated elite depriving the state of much needed skills thereby feeding into and exacerbating the decline in service delivery (Azarya and Chazan 1998, 121). External exit has political costs as ‘the exodus hampers the growth of the opposition within the country and reduces the chances of political change’ (Azarya and Chazan 1998, 123; Herbst 1990b, 186). However, the out migrations also act as the ultimate performance appraisal tool informing management of the citizens’ assessment of the public delivery standards.

Hirschman (1978, 103) observes that states experiencing equally massive out migration can adopt radically different responses. In post World War II Ireland, out migrations were viewed by the authorities as problematic and causing a deleterious brain-drain and the state responded by enacting economic policies to develop Ireland and halt or ultimately reverse the out migration trend. During the same period when the German Democratic

Republic experienced similar challenges, it did not reform but instead physically halted the migrations by erecting the Berlin Wall in 1961.

A variant of external exit significant in developing countries involves the migration from rural to urban areas for better quality services. In Zimbabwe, the traditional pattern of student movements between the rural and the urban areas involved students migrating to the urban areas for superior and cheaper educational services. Besides the external exit dimension, exit takes two internal forms which though distinct are not mutually exclusive.

Internal exit does not involve movement out of the state's geophysical space but mere disengagement from current relationships and seeking alternatives services from providers in the private and public sectors perceived to be offering a better quality of services. Internal provider exit involves leaving a particular public service provider due to dissatisfaction with the service quality for another public service provider (Campbell *et al* 2007, 6). An example of internal provider exit would be transferring learners from a public school perceived to be offering an unsatisfactory service to another public school perceived as offering better quality of service.

Internal public exit involves leaving the public system for the private sector (Campbell *et al* 2007, 6). The failure by the public schools and hospitals to deliver quality public services lead consumers to access alternative services from private service providers. However, due to the high costs, the private enterprise services are only accessible to the few quality conscious and resource-empowered citizens. Internal public exit also involves the workforce seeking self-enclosure, moving away from the centre and enclosing themselves against the vulnerabilities associated with a weakening state (Azarya and Chazan 1998). Skilled labour moves from state employment into the private sector.

Through self-enclosure, citizens facing a decline in service from the state attempt to manage their suffering silently. They seek to increase the resources and incomes through engaging in extra production, moonlighting or a more judicious management of the

household and community resources. Self-enclosure relies on the traditional and primordial structures (Azarya and Chazan 1998, 129) that have elsewhere been classified as elements of social capital (Kinyanjui and Khayesi 2005; Grootaert and Bastelaer 2002; Narayan, D. *et al* 2000; Putnam 1993).

Internal public exit might result in increased reliance on the informal system. The parallel market becomes the source of most commodities not available on the official market. An attempt at forcefully controlling the parallel markets further weakens the state as it fails to enforce its own laws (Azarya and Chazan 1998, 126). The parallel market will often operate without official penalty and sometimes even condoned by the law-enforcement agents as it gradually becomes imperative to maintain the parallel market as a necessary adjunct to the failing official system.

The magnitude of the exit, both internal and external types, determines whether the exit strategy contributes to solving the problem of declining performance or exacerbates the performance deficits. Exit in small manageable quantities might actually be welcome as it helps the state rid itself of troublesome quality conscious customers before they influence customers who might not be very quality conscious. In the nineteenth and twentieth centuries, there was massive migration from Europe to America welcomed by Europe as it rid them of dissenting elements and at the same time “the outflow did not provoke any visible political system or dangers” (Hirschman 1978, 101).

To contribute to the recovery of a declining system, exit then needs to be in small manageable quantities, just enough to signal the existence of a problem. At wholesale scale, exit debilitates the struggling system and diminishes the chances of recovery. Exit in whatever magnitude can also deprive a failing organisation the voice of the empowered, quality conscious citizens, the ones who are willing to point out to the management, the nature of the lapses and the recovery measures required to improve the services. Exit is also inherently limited in its contribution towards the recovery of a declining organisation as its mere existence is only indicative of something that might be a problem and does not follow through to isolate the problem.

2.2 Voice

One option available to consumers facing a decline in service delivery is to stay on despite suffering from the failure of public goods. Those who stay on may resort to voice, essentially making representations for improvements in the quality of the service or good. Broadly, voice is the expression of dis/satisfaction with the service delivery through the political, administrative, legal, and media channels (OECD/DAC 2008, 17). In the context of service decline, Hirschman (1970, 30) aptly defines voice as,

Any attempt at all to change, rather than escape, an objectionable state of affairs, whether through individual or collective petition to the management directly in charge, through appeal to a higher authority with intention of forcing a change in management, or through various types of actions and protests including those that are meant to mobilize public opinion.

Voice exists in different dimensions and this framework identifies three types: individual voice; collective voice voting; and collective voice pressure politics (Campbell *et al* 2007, 7). Hirschman's framework does not recognize the distinction between individual and collective voice (Dowding, John, Mergoupis, and Van Vugt 2000, 491). The original formation by Hirschman does not recognize that voice might be used to express satisfaction with a service. The first type of voice is individual voice where an individual complains about the poor public services to officials. The individual directs their complaints to the local provider, the local or national bureaucrats, the elected local or national representatives, officials of political parties and other sub-national authorities such as the traditional leadership (Campbell *et al* 2007, 7). Dowding *et al* (2000, 473) define individual voice as those, "actions where the intention of the individual in acting is to bring about the desired effect solely through that action".

The exercise of voice can also be collective, involving representation by groups. Collective voice refers to "actions where the intention of the individual in acting is to contribute to the desired effect through that action" (Dowding *et al* 2000, 473). There are two types of collective voice: collective voice pressure politics and collective voice voting (Campbell *et al* 2007, 7).

The second type of voice, collective voice pressure politics, involves pressure lobbies, coordinated mass meetings, demonstrations, sit-ins, occupations to rebellious revolts and popular uprising in the form of riots (Ness 2009, lxxi). Collective voice pressure politics might be used ‘to defend satisfactory services against erosion or attack poor service provision’ (Campbell *et al* 2007, 7). In the Zimbabwean situation, collective voice pressure politics might also involve establishing new alliances in the ubiquitous factions in the ruling Zimbabwe African National Union-Patriotic Front (ZANU-PF) party and the main opposition party, Movement for Democratic Change (MDC). Collective voice pressure politics necessarily involves the use of the horizontal voice (Dowding and Peter 2009, 6).

The third type of voice is collective voice voting at the local and national level elections. The collective voice voting is exercised through the recall of representatives during the regular elections. The electorate rejects the representatives judged to have performed poorly in favour of candidates promising an improved service. In postcolonial developing countries, the efficacy of collective voice voting might be limited (Englebert 2009, 7) as the poor have little or no power over the elected representatives, “who may be embedded in clientelist or non-competitive political system” (OECD/DAC 2008, 17). Besides registering discontent with the government or the elected representatives, collective voice voting can also be used ‘to defend the elected governments against an opposition party that the electorate perceives will provide worse services if elected into power’ (Campbell *et al* 2007, 7). The two types of collective voice are subject to the collective action problem where groups with a common interest may fail to achieve that interest because of the individual incentives (Ostrom and Walker 2003, 295; Olson 1971). The three types of voice are not mutually exclusive and often interact in a dynamic fashion. The prospect of collective voice voting during elections facilitates individual voice as voters make demands on candidates vying for office.

Voice is a more useful contributor to the recovery of an ailing organisation. Voice in its three forms specifies the nature and extent of the problem and the corrective action required for recovery. As with exit, too much voice can hinder efforts at recovery as the

system can only improve if few customers exercise voice providing management with an opportunity to redress the grievances raised. The state also requires some minimum level of exit and voice to 'register feedback about its performance' (Hirschman 1980, 441).

2.3 Direct Action

When facing a decline in service delivery, communities do not always exit or resort to voice in Hirschman's sense as a primary means of improving the quality of the public services. Indeed, individuals, households and communities can go beyond exit and voice as strategies of registering discontent by coalescing and directly acting to produce public goods at the local level. Local direct action is the deliberate and mostly judicious initiative by the individuals, groups and communities to create public goods and services in place of the support the state can no longer provide. Through local direct actions, people seek individually or through cooperative action to create access to resources even in the absence of state support. Local direct action is a distinct and different response. Unlike voice that seeks the improvement of the services by others, direct action seeks to produce and distribute the required goods and services. In this framework, direct action becomes the third category of response to the dissatisfaction with the public service delivery. Hirschman's original framework did not envisage the alternative of direct action.

This framework postulates the alternative response of direct action as having three types: individual direct action, communal direct action, and externally supported direct action. Individual direct action involves the direct provision of the services by the individuals. In the place of declined educational services, a parent might hire teachers to tutor a learner or individually procure learning materials that under normal circumstances are provided by the school. In health, the individual actions would include self-medication when patients attempt to meet their own medical care requirements.

Externally supported direct actions include those interventions sponsored by individuals, corporate and non-governmental organisations (NGOs) from outside the jurisdiction. The external support is meant to help the production and distribution of goods and services

previously provided by the state. The NGOs play a critical role in externally supported direct action as they are more than pressure groups merely seeking to influence government policy but also take an active role in service delivery. NGOs can influence the local options and action as they provide the necessary resources. As the state fails to deliver the key services, NGOs respond by injecting more resources and become some of the major players generating nodes of power. The NGO also typically have bigger budgets than local governments, pay regular and higher salaries and hence can attract the skilled personnel from the public sector, further undermining the capacity of the failing public system (Zivetz 2006, 18).

Communal direct action involves groups and community members acting collectively to compensate for the missing public goods. Communal direct action might be in the form of monetary contribution to purchase the services or goods and the contribution of labour for the production of services and goods. As a response strategy, communal direct action suffers from the usual collective action problem. The size of a group is crucial in the attainment of collective action (Ostrom 2007, 18). The small, homogenous groups that discuss the production of the public goods in a face-to-face interaction have higher chances of succeeding at communal direct action efforts. In small homogenous groups, it is easier to build a reputation, trust and reciprocity to overcome the temptation to pursue short-term benefits all characteristics of high levels of social capital (Putnam 1993; Grootaert and Bastelaer 2002). Trust is important in reducing the transaction and enforcement costs. Small groups can effectively share information and coordinate activities (McCarthy 2004, 1). However, face-to-face, interaction among small heterogeneous groups can also lead to conflict, competition and little cooperative effort.

When groups are large, the costs of negotiation, monitoring and enforcement increases and so does the overall transaction costs. Members in a large group are tempted to 'free ride' on the assumption that their small contribution will not be detected or reduce the overall quality of the public goods produced. Because of the high transaction-costs and free rider problems, the larger groups are less successful at cooperative effort.

The previous achievements at collective effort also influence the future success at communal direct action leading some communities to be more successful than others at cooperative effort (Ostrom 2007, 16). Previous successes with collective action tend to promote future cooperation “in expanded set of activities creating a virtuous circle” (McCarthy 2004, 1). If actors benefited from previous cooperation, they would want to maintain their reputation and expect reciprocity from others hence become predisposed to cooperate in collective action. Previous failures tend to reduce the chances of future successes as, the “failure in collective action now will have a negative impact on the capacity of the community to engage in successful collective action in future” (McCarthy 2004, 2).

High variability in the distribution of wealth and the different opportunities to access off-farm income has an influence on the success of collective action (McCarthy 2004, 2). Francis and Amuyunzu-Nyamongo (2005, 19) in a study of responses to state service declines in rural Kenya, established that participation of the very poor in collective action is limited by the lack of surplus resources (including time) for collective action. Given the uneven participation of the different groups, communal direct action unchecked provides an opportunity for ‘social exclusion and inequality’ (OECD/DAC 2008, 9).

Some public goods are more amenable to production through the communal direct action than others (McCarthy 2004, 1). It is easier to provide goods with local externalities at the local level whilst those with extended externalities are better provided by the local community in conjunction with the government or by the central authority on its own. When citizens are successful in communal direct action, they can avoid the state and adopt neo-secessionist behaviours leading, to internal exit inadvertently.

2.4 Passivity, Apathy and Helplessness

Despite a decline in the public services, some people due to a number of factors might not actively respond and suffer in silence (Dowding et al 2000, 473). Passivity emanates from two sources: disempowerment and ‘free rider’ problem. de Mesquita *et al* (2003, 354) also argue that, ‘individuals can be disgruntled about their institutions but take no

action, showing patience while they wait for circumstances to change and improve their lot'. In a situation where the state fails to deliver the key services on which the poor are dependent upon, the decline in the service adversely affects the poor more than the non-poor. The disempowered group is vulnerable and gradually becomes consumed and motivated by matters of day-to-day survival and not the seemingly secondary issues of the state performance.

There is a minimum level of subsistence required for citizens to engage in civic activities of voice. The poor fail to reach this threshold during the periods of declining state capacity to deliver public services. The decline in the public services does not only lead to exit, voice, or direct action but has a debilitating effect on the population, disempowering and necessarily turning the very poor apathetic. Despite recognising the deteriorating standards of living, Zimbabweans “paradoxically, are resigned to the dominance of the incumbent government” (Bratton, Chikwana and Sithole 2005, 78). This study contends that in the fourth response category, extreme deprivations can push the costs of exit beyond reach of the poor and simultaneously mutes voice leading to passivity. Based on hard calculations, the disempowered who perceive no possible strategy for the improvement of the public services may decide that passivity is the most cost-effective option.

Passivity can be a product of the free rider problem. Citizens might be interested in seeing improvement but do not take action, appear apathetic as they expect someone else to provide the public good (Hirschman 1980, 432).

2.5 Spiritualism and Tradition

The fifth coping mechanism to stressful situations involves those with little hope in individual success with voice and rely on faith to explain their predicament (Barry 1974, 85). It involves attributing the causality of individual and group inability to cope to some supernatural phenomenon. Problems are explained as acts of the supernatural as one of the central “functions of religion is to help people deal with the deleterious effects of adversity” (Krause *et al* 2001, 642).

Explaining problems as acts of God might be a form of protest, indicting government for the alienation of the poor and their vulnerability, essentially arguing that there is no hope in the existing social institutions (Rahmato 1991, 104). Under stress therefore, “spiritualism, new beliefs system, magic and cult activities are on the rise” (Chazan 1988, 131). The continued decline in public services ought therefore to give rise to more religiosity among the poor who rely on the public services for their day-to-day survival.

2.6 Loyalty

Loyalty is the ‘special attachment’ to an institution or community that affects an individual’s choice of response options to a declining quality of service. Of the three concepts in Hirschman’s framework, loyalty is the most criticized (Clark, Golder and Golder 2006, 2; Dowding *et al* 2000, 476; Boroff and Lewin 1997, 51; Laver 1976, 481; Birch 1975, 74; Barry 1974, 95). Some scholars have construed loyalty as an alternative to the primary responses of exit and voice (Rusbult, Zembrodt, and Gunn 1982, 1231). These scholars regard loyalty as a rational choice when there are no better alternatives (Clark *et al* 2006, 10). However, in this framework, loyalty is not a distinct response option like exit, voice, and direct action, but rather an orientation influencing the tradeoff between the different response options (Dowding *et al* 2000, 476).

The more loyal patrons of an organisation are prone to delay exit and they stay longer in the case of a service decline. On the other hand, “those who are unburdened by feelings of loyalty will be prone to exit, while the loyalists will resort to voice” (Hirschman 1993, 77, 194). The loyal members believe they can influence service improvement through efficacy of their voice and hence purposefully seek influence in organisations that they are members of. There exists a dynamic relationship between voice and exit as loyalty correlates highly positively with voice and correlates highly negatively with exit (Dowding *et al* 2000, 481).

Loyalty exists in two broad dimensions: brand loyalty and object loyalty. Brand loyalty, the one referred to by Hirschman, is where an individual is loyal to a given product, resists change and displays conservative attachment to that product (Dowding and John

2009, 6; Dowding *et al* 2000, 476). A brand loyal consumer is unwilling “to switch from one brand to another even when the other brand is either objectively better or objectively identical but cheaper” (Barry 1974, 98).

The second type, object loyalty depends on “one’s identification with the object of loyalty, and secondly the amount one has invested in that object” (Dowding *et al* 2000, 477). There is a difference between the ‘object of loyalty and the object one directs voice or chooses to exit’ (Dowding *et al* 2000, 491). The citizens may be loyal to the community as the object of loyalty but direct their voice at the leadership. Some citizens might identify with ZANU-PF as a liberation movement and continue to support it despite its lack of service delivery in government. Therefore, ZANU-PF can be the object of loyalty that retains support even if voters do not always agree with most of its policies and the leadership. Emotions, ethnicity and propaganda also feed this type of loyalty. Investment in an object such as contributing towards establishment and operation of schools and clinics increases the investor’s loyalty to that object. Being a community member who has invested in social capital in a community also increases one’s attachment and loyalty to the community.

The attachment and identification with the community might create some strong sense of loyalty such that even when faced with the dramatic declines in the quality of services, exit from the community is difficult and can be an “exceeding costly and painful process” (Dowding *et al* 2000, 477). Members of the community who have invested in social capital or public services might be more loyal to the community or the service, are reluctant to exit and therefore willing to voice or directly act to provide the missing public services.

The use of propaganda accompanied by the closure of alternative channels of information can effectively indoctrinate an electorate into identifying with the incumbent regime. Through propaganda, citizens become loyal to the state which might be viewed as a victim of interference by external forces and not as a cause of the service decline. The appropriate response by the community would be to defend the government against the

external aggressors. In Zimbabwe, the targeted sanctions imposed against the leadership by external actors were mythologised as the root cause of the state inability to deliver on health and education. This view of external causality of the decline might lead to direct actions by community to counter the actions of the external actors.

2.7 Political Patronage

Besides loyalty, political patronage is another orientation that influences the choice of response options to the decline in public services. Rulers can also ensure continued support and compliance of citizens through two strategies: coercion and extending material personal benefits under a patronage system (Bratton *et al* 2005, 96). The application of force can ensure support as citizens are coerced into submission.

Despite the deteriorating macroeconomic situation, some individuals benefited from the political patronage by the ruling party as “there are apparently some elements in Zimbabwean society who have benefited from ZANU-PF’s management of the economy” (Bratton *et al* 2005, 97). Citizens who benefit from the state mis/management of the economy remain supportive of ruling party because of past or anticipated future individual benefits. Recipients of the patronage benefits might use collective voice to defend the government against an opposition that threatens the continued enjoyment of benefits.

Some citizens become loyal because of being ‘locked in’ an organisation where exit is not feasible (Hirschman 1970, 102). Citizens can be ‘locked in’ in the public sector, for instance, they could temporarily escape low quality education in public schools but could not avoid the externality of low literacy rates and related consequences. The difficulty of escaping the externalities of public goods turns citizens who would otherwise have exited, to participate and encourages them to apply their voice instead. “The conviction that one has to stay on to prevent the worst grows stronger all the time” making it difficult for members who recognise they have a continual stake in the public good to exit a deteriorating public sector (Hirschman 1970, 103).

2.8 Interaction of Response Options

Hirschman's (1970, 45) original framework envisages that the citizens who are quality conscious and price insensitive are likely to exit at the first signs of a decline in the quality of a product. In education, the quality conscious parents in public schools are more likely to withdraw their children and enroll them at high fee private schools that provide an education service of superior quality. Such exits can be detrimental to the improvement of services as they deprive the school management of voice by the quality conscious and empowered parents who could point precisely to where changes are required. In that case, the management could have the signal that something had gone wrong but might not know what or how to resolve it. Exit taken by the empowered therefore undermines the development of voice.

Exit, voice, direct action, apathy and spiritualism are not mutually exclusive options and often interact and complement each other in a dynamic fashion. The ease of exit and direct action usually undermines the development of the three forms of voice. As opportunities for exit decline, the use of voice may increase. However, voice tends to be more effective if supported by a threat of exit. The sequencing of exit and voice is not predetermined and is situation specific. Citizens can exit and voice simultaneously, they can voice and if the desired outcome is not achieved exit, and can exit and then voice from outside (Dowding *et al* 2000, 491). Citizens who exercise external exit option and go into exile continue to exercise voice, demanding change and improved services. The exiles do so via the Internet and the shortwave radios stations.

2.9 Conclusion

The framework developed for this study recognises the different dimensions of voice and exit and incorporates other response options such as direct action, spiritualism, apathy and helplessness. This study postulates exit as having three types: internal public exit, internal provider exit and external exit. External exit typically involves out migration to other countries and the movement from one part of the country to another. Internal public exit occurs when communities leave the public sector for the private sector. It involves various forms of disengagements ranging from the reliance on the shadow economy to

self-enclosure. Internal provider exit involves leaving one public provider for another in the same sector.

This study conceptualises voice as having three types: individual voice, collective voice pressure politics, and collective voice voting. Individual voice in this framework refers to an individual complaining about the service delivery to public officials. Collective voice pressure politics involves collective actions such as protests, changing political party and intra-party faction allegiances. The other type of voice, collective voice voting, entails rejection of the poorly performing representatives during scheduled local and national elections or defending the government in power against an opposition perceived as likely to cause further decline in service delivery.

Communities do not always exit or voice when facing a service delivery shortfall. Indeed, they might organise to produce the public goods locally. The direct action can be in three types: individual direct action, communal direct action, and externally supported direct action. The size of the group, the degree of homogeneity and the type of public goods are all determinants of the success of communal direct action. There are apparent, persistent and underlying tensions between individual private interests and the collective public interests.

Citizens can also be apathetic, hoping for the natural recovery of the declining service delivery system. The various response alternatives are not mutually exclusive but can be deployed jointly and sequentially.

The framework for this study argues that exit has a limited effect on the improvement of service as it only serves to alert of the possible existence of a service delivery problem. It also deprives communities of skilled labour which is empowered to use voice to demand an improvement in service delivery. Voice is more effective as it is specific in diagnosis of the problem and the action required for improving the service.

CHAPTER THREE: METHODOLOGICAL ISSUES AND STUDY AREAS

3.0 Introduction

This chapter discusses the methodologies deployed in this investigation. The case study areas are presented against a brief background on their socioeconomic, geographic and political characteristics. This chapter identifies the population from which data was collected and explains the criteria used to select both the two cases and the individual respondents. Data collection procedures and analysis are also discussed in this chapter. The qualitative methodological approach guided this study. The primary methods of investigation employed in this study were case studies, documentary analysis, observations and in-depth semi-structured interviews. Ethical considerations, risks and assumptions associated with this study are discussed in the chapter.

The Rationale for Case Study

The relationship between a case study and other research strategies is not antagonistic but one of complementarities and the choice of a case study is a matter of tradeoffs between the strengths and weakness of each approach (Flyvbjerg 2006, 241). A case study is defined by Yin (2009, 18) as,

An empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident. The case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points and as a result relies on multiple sources of evidence, with data needing to converge in a triangulation fashion.

Case studies are appropriate in researches where the questions investigated are “how and why”, and the issues under study are beyond the control of the researcher and require in-depth investigation (Yin 2009, 11; Babbie 2004, 293). This study fulfilled these requirements. Firstly, the study focused on how communities responded to state incapacity to deliver public services in health and education. Secondly, state incapacity and attendant responses were contemporary and ongoing issues and thirdly, both factors of state incapacity to provide public services and responses thereto were beyond the immediate influence of the researcher.

Case studies can be within a state or across national units. One critical issue in the use of case studies is to determine the number of cases studied, whether they are single case or multiple cases (Yin 2009, 47). The number of cases selected for study invariably involves a tradeoff between detail and the opportunity to generalize (Mackie and Marsh 1995, 180). A limited number of cases may provide a wealth of detail but it is not possible to generalize these findings whilst a larger number of cases provides opportunities to generalise but details of individual cases are lost. The need for detail limited the number of cases in this study to two. The evidence from multiple cases rather than a single case is regarded as more 'robust and compelling' (Yin 2009, 53). The prevailing political environment also influenced the number of cases studied. The volatile political situation in Zimbabwe required an enormous investment of time over a sustained period to establish trust among respondents. Therefore, only a limited number of communities could be safely and effectively accessed within a year.

The case study approach was appropriate as it facilitated the in-depth and detailed analysis of the selected units (Casley and Lury 1987, 64). The case study was particularly relevant as the study sought among other objectives to investigate in depth key variables in order to establish the societal responses to the socioeconomic challenges. Comparative case studies are essential in the study of politics as it is difficult or impossible to apply controlled experimental designs as in natural sciences due to both practical challenges and ethical consideration (Mackie and Marsh 1995, 173; Lijphart 1971, 684).

The case study approach aimed at optimising an understanding of the individual cases rather than generating general hypothesis. Qualitative case studies do not aim to generate a representative sample of typical case. Rather purposeful sampling is used to reflect the diversity of the cases and phenomena under investigation and provide, "as much potential for comparison as possible" (Barbour 2008, 53). As argued by Stake (2005, 451), a good qualitative case study is one that offers the greatest opportunity to learn.

The choice of the case areas was purposeful, designed to encompass and guided by four criteria (Babbie, Mouton, Vorster, & Prozesky 2005, 288). Firstly, the selected case areas were communities. The communities had identifying characteristics such as agreed upon boundaries and traditional authorities. Each area had to be organised around or under a single institution of traditional leadership or administrative ward. Secondly, the cases constituted catchments areas for the provision of health and education services. Thirdly, in order to enhance diversity, the two cases selected were situated in different agro-ecological regions representing ‘contrasting’ situations (Yin 2009, 61; Flyvbjerg 2006, 230). One case was chosen from the dry region, poorer category and another from the high rainfall non-poor category. Since local authorities and missionaries provided most of the health and education services in rural areas, care was taken to choose cases that had facilities operated by both the local authority and missionaries adding to diversity. Fourthly, the cases were selected from rural areas. In a politically charged environment, the choice of the cases was therefore carefully made. As argued by Stake (2005) a random selection can lead one into ‘inhospitable environments’.

The choice of Zimbabwe as the site of research was significant. The country had quickly degenerated from a relatively strong postcolonial state recognised for its policies to facilitate increased access to health and education services for the poor majority, to one struggling to meet its basic state functions and avoid a possible implosion. The Zimbabwean state was unable or unwilling to provide essential public services including basic health and education services to many of its citizens. The health sector had deteriorated and clinics and hospitals lacked drugs and vital equipment. In schools, there was a critical shortage of textbooks and other learning materials. Both education and health sectors experienced severe ‘personnel haemorrhage’ as skilled personnel left the public sector for the private sector or emigrated.

As with all approaches, the use of case studies has both advantages and challenges. The disadvantage of multiple cases is the requirement for extensive resources often beyond the financial capacities of individual researchers (Yin 2009). The advantage of selecting a limited number of cases is that each, “can be intensively examined even when the

research resources at the investigator's disposal are relatively limited" (Lijphart 1971, 685). A disadvantage of the case study approach is the difficulty of generalising from a case study. Additionally, though biases can enter any research approach including surveys, in case studies biases are more frequent and more difficult to overcome.

3.1 Study Areas

Administrative Structures in Zimbabwe

Zimbabwe is divided into ten administrative provinces and split further into sixty districts. Harare and Bulawayo metropolitans are unique in that the administrative district and provincial boundaries are congruous. Each of the other eight provinces is made up of six to nine districts. Though an administrative district would normally contain more than one local authority, no local authority boundary cuts across district boundaries. Each local authority is divided into administrative wards with each ward represented in council by an elected councillor. The number of wards in a local authority ranges from six to forty-two. By 2007, there were eighty-eight local authorities in Zimbabwe, twenty-nine of which were urban and fifty-nine rural. A Provincial Governor appointed in terms of the Provincial Councils and Administration Act (1984) headed each of the ten provinces. Though not a member of Cabinet, the Provincial Governor, commonly referred to as the Resident Minister, was of ministerial status in government protocol.

There are four types of local authorities in Zimbabwe. The Urban Councils were established in urban settlements and the Rural District Councils (RDCs) in rural areas. Every province has a Provincial Council whose main functions are the coordination of the activities of local authorities. The fourth type of local authority was the traditional leadership whose roles and functions were fused with those of the RDCs.

At sub district level, there exist parallel institutions: the elected representatives, and the traditional leaders. A village is the smallest administrative structure and is headed by a village head (*Sabhuku*) who is a traditional leader. The sizes of villages varies substantially from five households to over a hundred households per village. The village head chairs the Village Assembly comprised of all adult inhabitants of a village. The Village Assembly

supervises the Village Development Committee (VIDCO), an elected structure. The village head reports to a Headman³ (*Sadunhu*), a sub chief who controls several village heads. Several Headmen report to a chief (*Ishe*). There are often one or more chiefs in an administrative district. Nationally, there are 266 chiefs in Zimbabwe and an average of three chiefs represents traditional leaders in an RDC as *ex officio* councillors. Each province appoints one chief who becomes an *ex-officio* Member of Parliament. The law disqualifies traditional leaders from standing for election as Members of Parliament or local authority councillors.

Elected institutions also populate the sub district levels. Several VIDCOs form a Ward Development Committee (WADCO). The WADCO covers an administrative ward area. The administrative ward boundaries are usually congruous with the headman area's boundaries. The VIDCO and WADCO structures were conflated with the ruling ZANU-PF party structures, with the same individuals assuming leadership in both party and elected local government institutions. The district and sub district structures of the ruling party women and youth leagues and the Zimbabwe National Liberation War Veteran Association (ZNLWVA) members had no legal authority outside that of interest groups but would often exercise power and influence³ over the sub district local government structures. As noted by Ruthereford (2001, 213), VIDCOs are often viewed and treated as vehicles of the ruling ZANU-PF party.

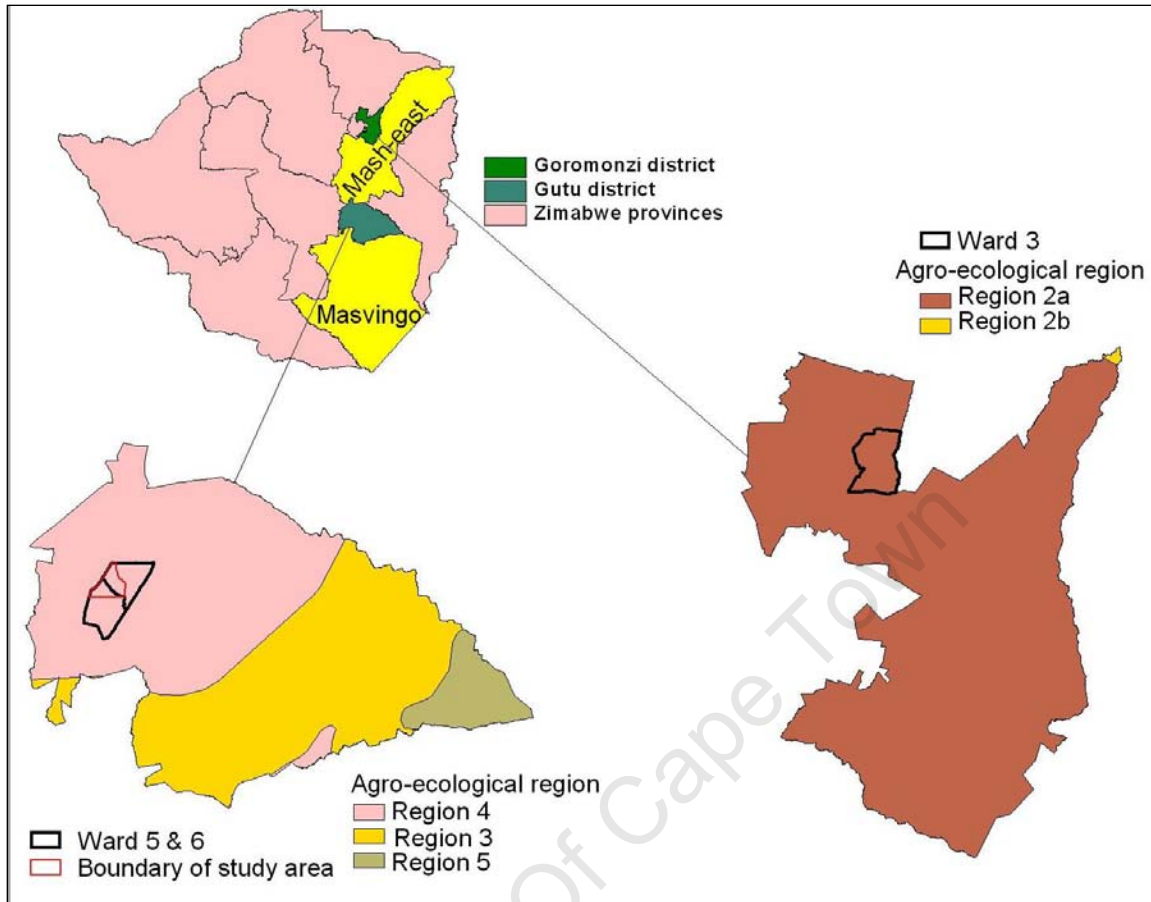
Traditional leaders coordinate development, maintain population records and collect taxes payable to the local authority. They are also empowered to deal with problems of land and natural resources conservation and management in their areas, preserve and maintain rural family life, punish crimes such as livestock theft and misuse of natural resources. The powers of chiefs extend to administrative, judiciary, planning and development co-ordination, traditional culture preservation and policing leaders at village level. On judicial functions, the chiefs have powers to settle minor disputes concerning: land, *lobola* (marriage dowry paid by the groom), and the burial of deceased. The

³ Headman is an official title but Shona tradition dictates that it is males (and very rarely women) who occupy the office of traditional leadership.

Traditional Leaders Act also gives chiefs ‘limited’ powers to arrest and report criminals to the Zimbabwe Republic Police. The traditional leadership and elected leadership coexist in a conflictual relationship with contested claims to legitimacy.

Location of study sites

The study investigated two rural communities in Zimbabwe: the Shumba community in the Goromonzi district, Mashonaland East province about 60 kilometres north of the capital, Harare and the Maotsa community in Gutu District, Masvingo Province in the southern part of the country about 240 kilometres south of the capital. The common feature of the two areas is the communal land tenure system. The two areas were traditionally ‘safe’ rural ZANU-PF dominated zones. The Zeruru ethno-linguistic grouping populated Shumba whilst the Karanga were dominant in Maotsa. The Zezuru and Karanga are all sub groups of the main Shona linguistic group comprising about 80% of the population in Zimbabwe. Both areas adjoined commercial farming areas taken over for resettlement since 2000. Some villagers acquired land rights in the new resettlement areas whilst retaining their communal landholdings. The livelihoods patterns and strategies in the two case areas varied considerably as dictated by geography and infrastructural factors such as access to tarred roads and distance to urban centres. Map 1 depicts the provincial boundaries, agro-ecological regions, the administrative district, and the location of the study areas.



Map 1 Zimbabwe, Location of Study Sites.

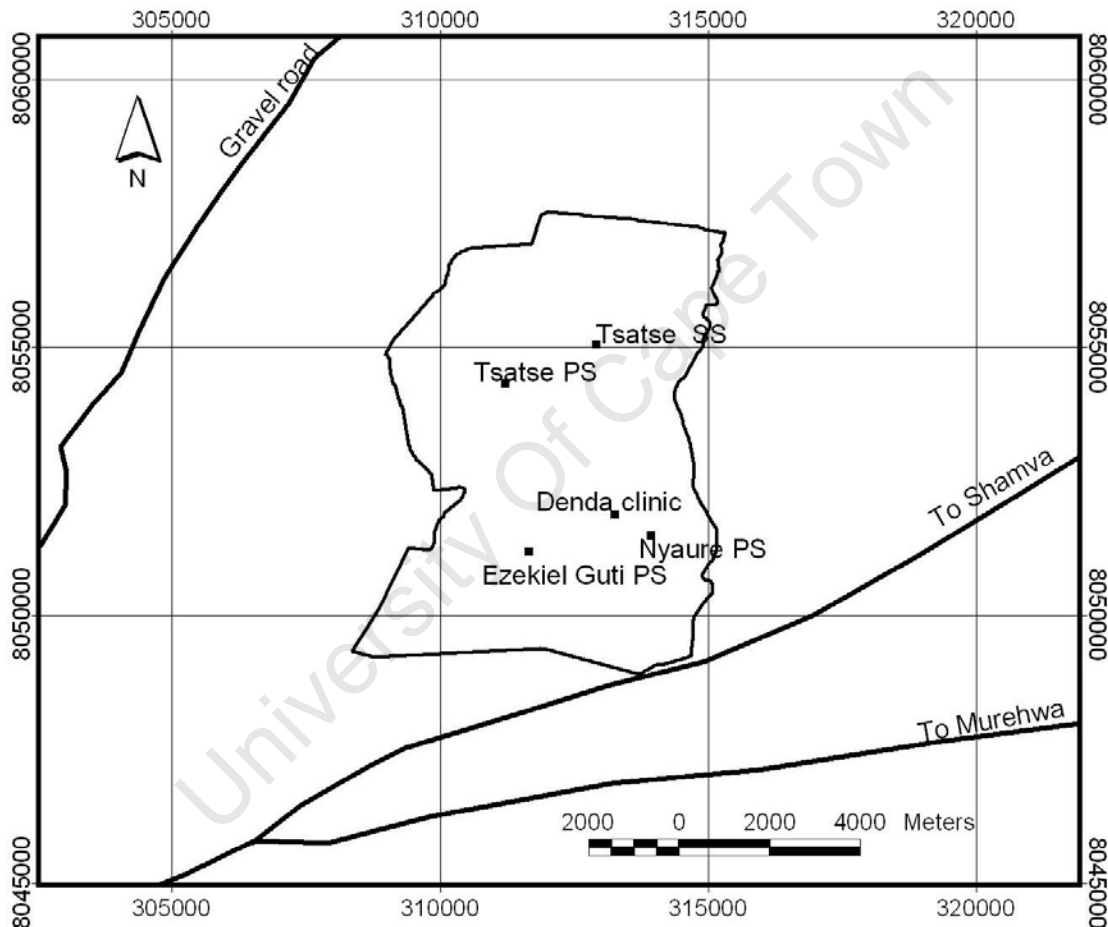
Produced by Department of Geography, University of Zimbabwe, Harare, (2008) for Norbert Musekiwa.

Shumba Community: Goromonzi District, Mashonaland Central Province

The first case studied was the Shumba community in ward 3 of Goromonzi district. The ward had a population of 5551 inhabitants and 1168 households and an average household size of 4,8 persons (CSO 2002a). Headman Shumba had twenty-two village heads under his jurisdiction. Headman Shumba area's boundaries were also congruous with the administrative ward boundaries. Shumba was located in the agro-ecological region 2A that received high rainfall and was therefore suitable for intensive crop farming. The main commercial activity in the area was market gardening with the capital city, Harare being the main market for fresh vegetables, fruit and grain crop produce. Shumba area's economy was influenced by its close proximity to the capital Harare. Indeed, Harare was nearer and more accessible than the Goromonzi district head offices.

The short distance, reliable public transport and availability of commercial haulers for farm produce improved access to the city.

One Rural District Council (RDC) clinic serviced the community. In the education sector, two primary schools and one secondary school serviced the Shumba community. The Rural District Council administered one primary and a secondary school whilst a church organisation in 2004 took over the other primary school previously owned by council. Map 2 depicts the location of the health and education facilities in Shumba community.



Map 2 Shumba Community, Schools and Clinic.

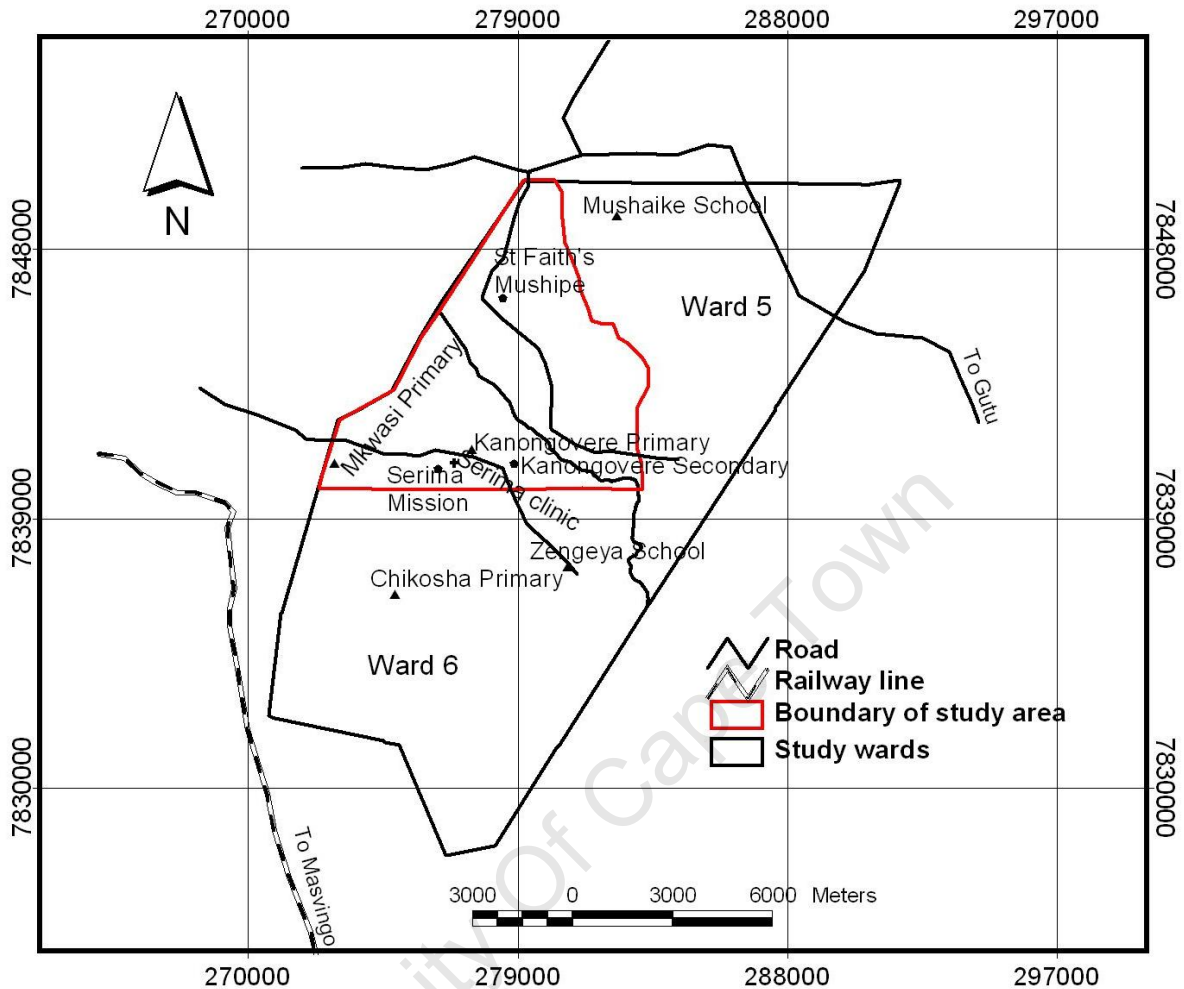
Produced by Department of Geography, University of Zimbabwe, Harare (2008) for Norbert Musekiwa.

Maotsa Community, Gutu District, Masvingo Province.

The second community studied was Maotsa community in Gutu district in Masvingo Province. The site is located south of the capital city Harare as depicted in Map 1. The

Maotsa community was located in administrative wards five and six of Gutu district. Twenty-two villages fall under Headman Maotsa. Maotsa had a population of 2903 inhabitants and 626 households with an average household size of 4.6 (CSO 2002a). Maotsa was located in agro ecological region 4 that is prone to seasonal droughts and consequential cereal food deficits. The main economic activity in Maotsa was subsistence agriculture, mostly livestock rearing. Livestock was important given that, “highly variable rainfall created numerous micro ecological zones so that crops less than half a mile apart might produce drastically different yields” (Davies and Dopcke 1987, 67). The propinquity of Maotsa to the Republic of South Africa (about 366 kilometers by main road to Beitbridge border port and far shorter as the ‘crow flies’ to the nearest border point) influenced the livelihood strategies of its residents. Men and lately women of younger age frequently travelled to South Africa in search of employment and trading opportunities.

Within Headman Maotsa’s area, there were three primary schools and two secondary schools. One secondary school was a missionary run high-fee paying boarding school which few local residents could access because of the high cost. The RDC was the responsible authority for the other three primary schools and a day secondary school. Map 2 shows the location of health and education institutions in Maotsa.



Map 3 Maotsa, Schools and Clinic.

Produced by Department of Geography (University of Zimbabwe, 2008) for Norbert Musekiwa.

Ownership of Schools and Clinics in Maotsa and Shumba

Local authorities or missionary organisations operated all the schools and clinics in the two areas. As Table 3.1 shows, the RDCs operated five out of the six primary schools with the remaining one administered by a church organisation. RDCs also run two of the three secondary schools with the missionaries operating one. Missionaries and the council respectively run the clinics in Maotsa and Shumba.

Table 3.1: Distribution of Health and Education Facilities in Shumba and Maotsa

Site	Council Primary School	Mission Primary School	Council Secondary School	Mission Secondary School	Council Clinic	Mission Clinic
Shumba	1	1	1	0	1	0
Maotsa	3	0	1	1	0	1
Total	4	1	2	1	1	1

Source: Survey Data 2008.

3.2 Sample and Sampling Procedures

The village and household were the units of organisation used for sampling. Villages ranged in size from the smallest with a population of twenty-one to the largest with 617 inhabitants. The villages were categorized as small, medium and large. Villages with a population below 220 were regarded as small, those with a population of 221 to 350 were classified as medium, and those with a population above 351 inhabitants were classified as large. Two respondents were chosen from each small village and three from medium sized villages. Four respondents were chosen from each large village. At least one respondent from each village had to be female to ensure that the views of women were included because Shona society is patriarchal in organisation and decision-making. Focus group discussions (FGD) for specific population groups were held in each area. A minimum of four FGDs were held for each area, one each for girls, boys, men and women. The FGDs ranged in size from four to eleven participants. The eleven FGDs conducted in the two areas had a mean size of six members.

Interviews with key informants, mostly civil servants working in the health and education sectors, councillors, religious leaders, political party leaders, traditional leaders and businesspersons, were conducted at the community level. As shown in Table 3.2 forty-one key informants were interviewed, ten from Maotsa, fifteen from Shumba and sixteen from the national level.

Table 3.2: National Summary of Respondents

Case Area	No of Households	Population Size	Number of Respondents at Village level	Number of Key Informants	Number of Females	Number of Males	Number of FGDs
Maotsa	626	2903	51	10	28	33	4
Shumba	1168	5551	56	15	32	39	7
National level				16	7	9	
Total	1794	8454	107	41	67	81	11

Source: Survey Data 2008.

The total sample of respondents surveyed at the village level comprised fifty-six respondents from Shumba area and fifty-one from Maotsa. The study conducted eleven FGDs, four in Maotsa and seven in Shumba community. Data on the number of households and population, and sampled units per village is given in Appendix J and K for Maotsa and Shumba respectively. Appendix I gives the breakdown of respondents at the national level.

3.3 Methods of Data Generation

Primary and secondary sources were the main sources of data for the study. Secondary sources involved search and analysis of government publications and earlier reports and studies. Primary sources involved in-depth interviewing with individual respondents at village level, other key informants at community and the national level and FGDs. Additionally, data generation involved observing respondents from the two case communities. Non-participant observation was also a key source of information. As argued by Yin (2009, 115) triangulation, which is the use of multiple evidence sources, contributes to corroboration and yields more convincing arguments. Furthermore, triangulation enhances validity and reliability (Babbie *et al* 2005, 275).

The data collection for this study was undertaken between July 2007 and June 2008. The main units for data collection were the individual, household and communities. This study used semi-structured questionnaires for collection of data at the individual and household levels. An individual questionnaire guide covered aspects of demographic characteristics, access to public services, individual and community responses to the decline in the health and educational services. The questionnaire also facilitated informal

in-depth, semi-structured conversational interviews. Semi structured interviews allowed the researcher to get the data from the perspective of the respondents (Barbour 2008, 119). Most of the data collected was at ordinal level with less at nominal and interval levels.

Interviews

An interview is the active and interactive process of generating empirical data by asking people to relate about their lives (Babbie *et al* 2005, 289; Holstein and Gubrium 2004, 140). The interview conversation can range in a continuum from a structured survey to a free-flowing exchange depending on whether respondents are viewed as ‘passive vessels of answers’ or active participants in constructing knowledge (Holstein and Gubrium 2004, 144). The positivist conventional appreciation of interviews is that they are vehicles for transporting knowledge neutrally. However, as argued by Holstein and Gubrium (2004, 141) interviews are in fact interactive, involving both interviewee and interviewer in a collaborative effort of assembling meaning, as “respondents are not so much repositories of knowledge-treasures of information awaiting excavation- as they are constructors of knowledge in association with interviewers”. In that regard, the data from interviews was ‘generated’ and not ‘collected’ (Baker 2004, 163; Barbour 2008, 89). The interview guide used in this study consisted of open-ended questions that were used as a checklist during the interview and had no specific order (Devine 1995, 138). Qualitative interview guides provide for probing by the interviewer on unclear responses, allows respondents to ask questions and tell their stories in their own language and idioms and the respondent could elaborate on answers (Devine 1995, 138).

As noted by Kumar (1999, 110), interviews are appropriate for rural communities where a sizeable number of respondents had low levels of literacy thereby making self-administered questionnaires problematic. To avoid interrupting the flow of conversation, an audio recorder was used to record the interview proceedings. The recorded interviews were replayed later and content analysed. Mechanically recorded evidence had an advantage that the audio recordings were often replayed several times before drawing any conclusion (Kumar 1999, 108).

Interviews were also appropriate for collecting information from a politically charged Zimbabwean environment. Most respondents required to know the identity of the researcher and get the personal assurance before they would provide any information. Due to the open-ended nature of the questions, interview guides typically lead to lengthy interviews effectively limiting the number of respondents that could be covered in a given time period. It was only possible to interview a maximum of three respondents on any given day. This was consistent with observations by Kumar (1999, 115) that interviews take a long time to complete.

As part of the in-depth interviews, the interviewer also observed the settings for use in interpreting the findings. As noted by Devine (1995, 138) observation is a key component of the in-depth interview. In using the non-participant observation, the researcher remained a passive observer, listening, watching activities, and making inferences. The method was particularly relevant when gathering information from community activities like parents and teachers' association meetings, farmers' association meetings and 'community report back meetings' by councillors. Observation can be critical for collecting corroborative evidence and creating new insights, "for instance, the condition of buildings or work spaces will indicate something about the climate or impoverishment of an organisation" (Yin 2009, 109). Furthermore, photographs were taken during observation, as they can be a forceful way of conveying the case attributes to an outside observer (Yin 2009, 110). The researcher also took part in several community activities such as funeral wakes. Events such as agricultural shows, opportunistic infections clinics were also observed. A lot of anecdotal evidence was gleaned from observations of such social action. This approach to the study was informed by a caveat from Yin (2009, 70) that in undertaking non-participant observation the researcher needs to be a keen listener, actively searching for hidden messages in the activities and including following on the denotative meanings embedded in speech. The insider perspective was important to understand actions, decisions of actors from their own frame of reference (Babbie et al 2005, 271). The local indigenous language, Shona was used for data collection.

Focus Group Discussions

Focus group discussions were one of the significant data collection techniques employed in this study. FGD is a method of generating data through informal discussion of a small group guided to focus on a particular topic or issue (Babbie 2004, 302; Wilkinson 2004, 177). A moderator, who asks questions, maintains the direction and flow of discussion and guides the informal group. The focus group is usually composed of members sharing common attributes, such as gender, age and occupation. The focus group interviews technique was relevant in getting information on community views on adequacy and appropriateness of coping strategies adopted. As argued by Barbour (2008, 18) focus groups' value "lies in their capacity to illuminate group process and the way in which meanings and even action plans are developed and refined through interaction". The FGD covered aspects regarding characteristics of the community, access to public service and social amenities, community organisation and decision-making, relationships and participation. This participatory method sought to establish the opinions, attitudes, perceptions and voices of the respondents and the method potentially provides rich detailed accounts and insights, thereby increasing the opportunity to understand the phenomenon under investigation (Narayan *et al* 2000, 25).

Document Search

The study examined and analysed central and local government policy and legislative documents relating to provision of health and education. Monitoring and evaluation reports by government agencies such as the Central Statistic Office and Department of Social Welfare were examined. The study also examined reports by international organisations such as UNICEF, World Bank, United Nations Development Programme (UNDP) and non-governmental organisations like the Zimbabwe Vulnerability Assessment Committee (ZIMVAC).

The libraries of government departments were invariably a repository of useful data on departmental activities despite most of them being operated by unqualified and under-qualified personnel. Most of the data and information generated by government departments were lodged in departmental libraries and access is open to all citizens. A

researcher can easily get 'sensitive documents' from government departmental libraries that civil servants are unwilling to release under the notorious guise of the Official Secrets Act.

Recruitment of respondents and establishing rapport with communities

Entry into the sites was preceded by a period of establishing reliable contacts at national, provincial and local levels. At the national level, the researcher relied on former colleagues in the civil service⁴. Most of the researcher's former associates in the civil service had risen to senior levels in central and local governments. Friends and former colleagues in the Ministry of Local Government, Public Works and National Housing (MLGPW&NH) were useful in sharing the general political environment, potential dangers of operating in rural areas and the requirements for conducting research in these areas. Former colleagues in MLGPW&NH specifically advised on the requirement to get clearance and cooperation of the local traditional leadership in the respective areas. In a study on Zimbabwe, Nhema (2002, 6) noted that previous connections in the civil service and political society were useful in accessing data. However, Nhema (2002) also warns of the need to guard against biases that such pre-existing connections could bring to data collection and analysis.

Contacts in the security forces were particularly useful in reinforcing the political etiquette in rural Zimbabwe and provided useful hints and contacts on the ground. Such contacts were useful and provided a sense of security that in the event of security problems in the field one could call upon them for relief⁵. As noted by Jacobs (2006, 162) a perception of safety, even if it were not a reality was important when researching in dangerous environments. The risk of arrest by the security forces and harassment or

⁴ The researcher had worked for the Ministry of Local Government, Public Works and National Housing (MLGPW&NH) head office, for a total of ten years from 1990 to 1995 and 1997 to 2001 starting as an administrative officer and rising to the position of National Programme Officer at the time of resignation. Over and above the primary responsibility of supervising the functions of local governments, the MLGPW&NH was responsible for the administration by traditional leadership. The researcher was also a University of Zimbabwe employee from 2002 to 2007.

⁵ Under the Public Order and Security Act and the Access to Information and Protection of Privacy Act, a researcher could be guilty of many offences including having a meeting of more than four people without written consent of the police.

confiscation of notes and audio recordings by the ubiquitous ZANU-PF Youths League⁶ and rogue elements of the war veterans of the liberation struggle was present. The highly polarized political environment that prevailed immediately prior to the harmonized elections aroused suspicions regarding any ‘stranger’ spending a long time with the villagers⁷. The perceived risk was consistent with Kriger’s (2003b, 104) observations that war veterans who had unfettered access to security agents often applied brute force on suspected enemies and did so at will as they were protected against the law. Bratton, Chikwana and Sithole (2005, 80) reported that the youth militias could punish citizens for a variety of offences, including failure to produce ZANU-PF party cards on demand. A precautionary stance taken was to keep copies of the collected data in a location far from the researcher’s temporary residence.

Acquiring statistics at the national level proved to be a difficult task. Even when the researcher was armed with the requisite, Ministries’ ‘clearance letters’ some officials were still reluctant to provide data as everything was classified as ‘state secret’. As noted by Rotberg (2007, 21) regarding the highly repressive regime in North Korea, “everything that is not specifically permitted is forbidden”. However, a substantial number of civil servants were still willing to assist and grant interviews upon guarantees of anonymity. Civil servants who consented to interviews perceived the risk to be minimal as they anticipated a change of government or the collapse of the state that appeared imminent⁸.

The beginning of the fieldwork in June 2007 coincided with a government-launched programme, Operation Reduce Price (*Dzikisa Mitengo*) that for three weeks made meaningful business impossible. The Operation directed traders to reduce prices by half or to those prevailing by 17 June 2007 whichever was lower. For three weeks after launch of the operation, it was difficult to procure any provisions for the study as suppliers held on to their stocks. Traders caught by law-enforcement agents transacting at prices above

⁶ Ranger (2005, 222) quoting the Solidarity Peace Trust records that, “the youth militias so created are used as instruments of the ruling party to maintain their hold on power by whatever means necessary, including torture, rape, murder and arson”.

⁷ Section 5.6 has a brief discussion on the then prevailing political situation and impending implosion.

⁸ Section 5.6 discusses the political situation.

those announced by government undertook supervised sales or had the goods forfeited to the state.

The entry into the communities took a long time. It took six weeks establishing relationships, networks and rapport with gatekeepers before the first interview. The researcher was patient, taking caution from Jacobs (2006, 165) that though necessary it takes time to identify and train fieldworkers and develop rapport as “this requires patience and persistence”. However, as data collection in Shumba was ending efforts were initiated to establish contacts in Maotsa. The first act in establishing rapport was to identify the gatekeepers and possible sponsors. In both cases, the aid agency employees and civil servants stationed at the local level who had worked with the communities for long periods acted as gatekeepers and sponsors. They were familiar with the community and well acquainted with the local leadership. The sponsor would advise on the power hierarchy and dynamics in the community. In all cases, they would assist in identifying a local who would act as a sub-sponsor of the project. From an initial list of two and three sub sponsors for the respective area one was selected in each case. Invariably, the chosen sub sponsor had some blood relationship with the Headman for the area and was of good standing in the community.

It took some time to motivate the aid agency workers on the study. However, once they were convinced about the purpose of the study they were prepared to act as sponsors. As noted by Jacobs (2006, 163), a gatekeeper is a critical individual when establishing the researcher’s credentials and should be someone highly regarded in their own community. The research assistant in Maotsa proved to be well respected and efficient to the extent that within two weeks of beginning the interviews, seven potential respondents came forward on their own for interviews.

After establishing rapport with the sponsors, the next phase was getting the mandatory authorization and clearance from the local leadership. The charged political environment required that the local traditional leadership and ZANU-PF representatives approve the study. It was a lengthy process getting the clearance from the traditional leadership. In

both cases, a request for clearance to interview members of the community was submitted on the first contact with the traditional leader. In all cases, permission was granted only after the Headman had consulted his council of advisors.

In Shumba, permission was immediately granted on the date of the scheduled interview with the Headman and his advisors. However, in Maotsa the researcher and his assistant were required to meet the Headman's council that consisted of the Headman's brothers. In the meeting, the Headman's council sought to verify the researcher's credentials, establish the objectives of the research and the potential political risk given that the harmonized general elections were due within three months. At the barest minimum, the study had to be perceived as pursuing a non-subversive agenda. As noted in other studies in Zimbabwe, there was need therefore to constantly engage ZANU-PF and the security agencies in the area and convince them that the study was apolitical and relatively innocuous (Mutimukuru-Maravanyika *et al* 2008, 19).

After elaborating on the objectives and use of the research output, permission was granted on condition that the researcher and his assistant would refrain from getting involved in political activities whilst undertaking the study in the area. It was a condition difficult to meet but kept. It was difficult to appear apolitical in a heavily politically polarised environment.

On one occasion, the campaign manager of the rival faction of the ruling ZANU-PF party commandeered the researcher's vehicle for "party business". I politely declined the request indicating that complying would be in breach of my professional ethics, conditions agreed with the traditional leadership and equally important that even if I wished to assist, the budget for the study was too constrained to accommodate any extras. This was 'generously' interpreted as exhibiting sympathies for the rival faction. The researcher's name came up later as one among many 'suspects' that had allegedly influenced the voters against the ruling party. However, the research assistant successfully argued that the research process was innocuous and could not have had even a remote effect on the electoral process. The agreements with the traditional leaders to

undertake research were exceedingly fickle to the extent that they remained valid and binding as long as they were not questioned or rescinded by the powerful war veterans or youth militias. During interviews, respondents often queried if ‘authorities’ had given clearance. All respondents recognised the clearance given by the local traditional leadership.

In both cases, the Headmen insisted that the research team obtain consent of individual village heads before interviewing respondents from each village. That condition entailed negotiating with and getting informed consent of all the forty-four village heads. In undertaking the lengthy and multiple negotiations caveat was taken from Mararike (1999, 26) that research in the Zimbabwean villages was a slow process as there were no shortcuts to entering the communities.

The communities also made requests on the research team. Community members took the opportunity to access certain items and services through the research team. The most common and benign request was for information on general entry requirements to the University of Zimbabwe. The researcher regularly updated himself and advised accordingly. A small number further requested assistance to get their children enrolled at University of Zimbabwe to which it was advised that the researcher had no influence on such matters and that it would be highly irregular procedure of gaining admittance into the University. Upon discovering that the researcher was a beneficiary of a fellowship grant, some respondents requested assistance in linking to donors for possible funding of individual or community projects, a request that invariably could not be satisfied. Some respondents requested an ‘educated’ analysis of the political and economic crisis they were facing and generally wanted the researcher to make predictions of the results of the upcoming harmonized elections for the President, Senate, House of Assembly and local councils. The rehearsed response was that it would require a survey to generate a prediction for an outcome of the election. In turn, I requested their predictions which they gladly shared.

Another common request from community members was to provide transport in emergency transfers to referral hospitals. Such requests were common and complied with in all instances. When offered payment for the hospital transfers, it was declined as the researcher insisted that it was a form of giving back to the community that was sharing secrets of their lives. There was an odd request from a Headmaster from Shumba in 2007 to transport the school examination scripts to the local receiving centre that was complied with⁹. In some cases, there were requests to bring agricultural, food and medical provisions from town. It was a request rarely fulfilled due to shortages of goods on the formal market and the respondents appeared to appreciate the problem. Yet another request was to pass on letters and messages between parties in the urban and rural areas. In one case, a widow requested that the researcher use his own mobile phone to contact her son and request assistance with outstanding hospital fees. The son was also supposed to pay for the cost of the phone call. However, since the cost of making the call was more than the required Z\$8,000,00 the researcher prudently donated the money that was less than US\$0,05 using the informal market exchange rate between the United States dollar and the Zimbabwe dollar.

The research team was on more than one occasion, drawn into local disputes with conflicting sides vying for support. The lobbying was particularly intense in the case of an irrigation project in Shumba following an international aid organisation's withdrawal of a pump to a group of women farmers. The head of the Agricultural Technical Extension Service (Agritex) and chairperson of the women cooperative grouping jointly lobbied against the councillor and the aid agency. The councillor on the other hand made a point that all understood why he had recommended the withdrawal of one of the two water pumps previously donated to the group. It was difficult to listen to all parties in the conflict and appear genuinely interested and at the same time not influence the outcome of the conflict.

Some respondents requested that the information they provided during the interviews be revealed to the higher levels of government as one respondent from Maotsa insisted, "tell

⁹ The deputy head who came along had the sole custody and responsibility over the examination materials.

the *chefs* (senior government and the ruling party officials) that this is the situation and that we are unhappy with government's failed promises, and please do not edit out any details".

It was helpful having research assistants with good knowledge of the community. The research assistants being local indigenes had knowledge about temperaments of some potential respondents. In one case, the research team was confronted with a situation of an excessively jealousy husband. The wife refused to take part in the interview in the absence of the husband. Prior advice assisted in framing a strategy to negotiate with the husband who had to give his 'clearance' for the wife to take part in the interview.

The research team found particularly confounding, the hospitality and politeness of the respondents. The respondents were generally friendly and charitable. In a majority of cases when the interviews ended, the respondents were quick to thank the research team for giving them an opportunity to share their side of the story. They were excited that they got anyone who was interested in their lives without ending up instructing them on what to do. This was consistent with Jacobs' (2006, 160) observation in studies of criminals that,

People in general are flattered when you want to talk to them about their lives, but especially when it is in the interest of 'science'.....These people are marginalized in virtually every other aspect of their lives. Your interest is refreshing and empowering. It reaffirms that what they have to say is important and that they have something genuine to contribute.

The research team also relied on kinship relations to access respondents. Most respondents inquired about the researcher's clan totem and clan lineage and responses to those queries always enabled the researcher to establish some kin relationship. In a study among Shona speakers in Zimbabwe, Mashiri (2003, 204) noted the importance and widespread 'use of kinship terms of address as forms of communicative resources to invoke social meanings in non-kin relation' in Shona interactions. Kinship relations invariably attracted obligations and benefits. When engaging a Shona community one has to structure the kinship relations in a manner most beneficial to both parties.

Conducting research in one's own communities has advantages but poses a dilemma (Mandiyani 2008; Mararike 1999). As a researcher coming 'back home' to do research I had relatively easy access to communities but faced the 'insider-outsider dilemma' (Mararike 1999, 22). As an insider I was quickly accepted as one of 'them' but resisted as an outsider who had acquired some 'ethical baggage and class interest' (Mararike 1999, 22) and had turned into an inquisitive investigator.

Data Recording Techniques

All the targeted respondents who agreed to be interviewed except for one civil servant agreed to be audio recorded. The civil servant who refused argued that given the existence of pirate radio stations hostile to the sitting government and broadcasting from the diaspora, she could not risk a recorded conversation and in any event, that would force her to think through her responses. The particular interview was not recorded and detailed notes were taken. Only two potential respondents, apparently both civil servants, declined to give an interview. The first, an extension worker, indicated that the local political leadership had recently questioned her political allegiance and she could not take any chances by sharing her opinions with 'strangers'. She further indicated that despite the Ministry of Health and Child Welfare head office's clearance, she required further permission from her immediate superior to give an interview.

The second potential respondent who refused to grant an interview was a head of a primary school. In that event, the chairperson of the school development committee was approached and he granted an interview. Respondents proved to be more skeptical if their input was to feed the popular media but regarded books as relatively benign. As noted by Ranger (2005, 242), "Zimbabwe is a country in which books have much less effect than radio and TV or other press". In that regard, once potential respondents were satisfied that the data being collected was not destined for the popular press but indeed academic purposes and at most a book, they willingly consented to engage and be audio recorded. In addition to audio recording, extensive field notes were taken. As recommended by Babbie *et al* (2005, 275) field notes were taken with two main objectives: to describe the

phenomenon and environment under study and to relate the observations to the guiding theoretical framework.

3.4 Analysis of Data

The primary unit of analysis was the community with the individual and household as embedded units of analysis (Yin, 2009, 31). Qualitative techniques, particularly narrative and discourse analysis based on membership categorization devices, were employed to analyse data from interviews, documents and legislation. Narrative and discourse analysis go beyond the traditional approach of “systematically grouping and summarizing the descriptions” as it provides “a coherent organizing framework that encapsulates and explains aspects of the social world that respondents portray” (Holstein and Gubrium 2004, 156). The traditional approach to data analysis was based on the assumption that respondents are repositories of knowledge and hence whatever they say in an interview can be put in themes and categorized to reveal some ‘real’ world state of mind (interior) and the social settings (exterior) (Baker 2004, 167).

The membership categorization framework pioneered by Sacks (1992) is based on the assumption that all respondents belong to a category of actors (Baker 2004, 164). The respondents were in categories of communal farmers, civil servants, school committee members, members of the local clinic committee, members of household and members of community, among others. Members of each category undertake activities as defined by their category, as most activities are category bound though there is interaction between the categories (Baker 2004, 166). The categories do not exist as simple aggregates but are organised into ‘collections of categories’ (Schegloff 2007, 467). A collection, which is a set of categories, often exists in pairs and contrasts, for example, male/female, young/old, teacher/parent and doctor/patient (Sacks 1992, 41). Local morality and cultural knowledge define the acceptable actions for each category (Baker 2004, 166). As a category, for example, members of the school development committee have specific activities different from those of parents and teachers though they interact with these other two categories. The categories are, as indicated by Sacks (1992, 41) and Schegloff

(2007, 469), 'inference rich', a means by which knowledge about people and how they should behave is stored and retrieved.

The study applied the three steps of analysis recommended by Baker (2004, 174). The first step was to locate the main categories and membership of people, institutions, phases and places and to identify any relational pairs and contrasts between these categories. The main categories identified were the community, parents and guardians, learners, teachers, patients, health professionals, faith based organisations, international aid agencies, and local leadership of village headman and councillors. The respondents specifically named some categories and only implied others. For example, those who openly opposed government policy were implicitly categorized as members of the opposition party. The very poor would usually identify themselves as 'people like us without many resources'.

The second step involved sorting out the various activities associated with each category. The school development committee, for example, was expected to represent the interests of parents and transmit concerns of teachers to parents. Baker (2004, 174) aptly emphasised the need to take into consideration even those implied activities for "the attributions that are hinted at are as important as any stated in so many words: hinted at categories or activities or connections between them indicate the subtlety and delicacy of much implicit membership categorization at work". The third step was to establish the connection between the categories and attributes and specifically how actors in each category are expected to or actually behave.

Analysis of data was in two phases. The first phase was in the field and the second phase after fieldwork. In the field, the study adopted an approach recommended by Bryman and Burgess (1994, 7) where:

strategies include: forcing oneself to narrow down the focus of the study; continually reviewing field notes in order to determine whether new questions could fruitfully be asked; writing memos about what you have found out in relation to various issues; trying out emergent ideas.

Post field analysis involved mostly membership categorization, coding, identification of emerging patterns and isolating inconsistencies.

Responses to the individual questionnaire were grouped into broad categories and post-coded. The coded responses were analysed using the Statistical Package for Social Scientists (SPSS) version 16. As observed by Barbour (2008, 162), the use of SPSS allowed data collected to be classified and produce cross tabulations permitting analysis of relationships between variables. The results of the SPSS analysis were complimentary to the qualitative interpretations of data. Computer aided tools for analysis could not in any way replace the researcher as the main analyst in case based research (Yin 2009, 129). However, as noted by Kumar (1999, xii), “statistics are useful in confirming or contradicting conclusions drawn from analysed data, in providing an indication of the magnitude of the relationship between two or more variables under study”. The use of mixed methods is particularly relevant for addressing complex research questions (Yin 2009, 63).

3.5 Ethical Considerations

The guiding ethical principle adopted in this study was, as forcefully argued by Babbie (2004, 29), designed to ensure that data generation and subsequent application did not harm the participants. Equally important was that participants took part in the research with informed consent. As a central government requirement, clearance was sought from government departments responsible for the sectors being researched. In that regard, clearances were obtained from the Ministries of Education, Sport and Culture; Health and Child Welfare and the Department of Social Welfare to obtain information about the Departments’ operations and to interview civil servants¹⁰. The MLGPW&NH also required that traditional leadership authorise all activities including research in their respective areas. Before any interviews were conducted, the headman and village head had to give clearance and informed consent.

¹⁰ Appendix B and C are copies of the clearance letters granted by the Ministries and used in the field.

Participation in the research was strictly voluntary and participants took part on their own free will. All participants were advised that they would be free to withhold any information that they might decide not to share with the researcher and furthermore could withdraw at any point if they felt like doing so for whatever reasons. In all cases, the objectives of the research and the application of the output were explained when seeking the clearance and consent. Individual respondents had to give their informed consent to partake in the interview.

Participants were advised that there were no direct benefits for participating except the satisfaction that they would have assisted in understanding the complex phenomenon of how communities adjust, adapt and cope with declining quality and quantity of the health and education services. Respondents had to give an affirmative response before proceeding with the interview¹¹. Specific permission to audio record was requested and a verbal consent was provided in all cases in the presence of the research assistant. A majority of respondents consented to have their identities revealed and their photographs published as part of this report.¹²

The study accorded participants adequate protection against harm. A caveat by Babbie (2004, 64) that revealing information about participants might embarrass them and endanger their lives, families, friendships, jobs or injure their self-esteem guided the study. In that regard, though the identity of the cases is disclosed, the confidentiality of the respondents was guaranteed. Names of individual participants were not divulged, instead pseudo names were used which may not in any way link the participant to the data collected. The study maintained each participant's right to privacy.

3.6 Risks and Assumptions

The major risk was that data collection was undertaken in Zimbabwe when the country was facing political and economic crises. Communities were polarised between the major political parties. The ruling ZANU-PF party and the opposition MDC were largely

¹¹ See Appendix A for full text that was read to respondents when seeking informed consent.

¹² Photographs were taken with the consent of the individuals or authorities concerned and the respondents gave their informed consent for the photographs to be published as part of the thesis.

intolerant of differing political opinions. In terms of political violence, Zimbabwe could be characterised as an “active volcano” to be approached with caution. Since 2000 violence had become an established feature of the Zimbabwean politics (Bratton *et al* 2005, 80). The political risk was significant given that data collection was undertaken up to a few months before the harmonised presidential, parliamentary and local government elections held on 29 March 2008. Given the above characterization of the host country for the cases, the researcher approached the study with extreme caution. The researcher’s association with the University of Zimbabwe as a lecturer in a large measure lowered the risk factors. Respondents generally regarded the researcher’s employment with University of Zimbabwe; a government owned institution as giving the researcher a ‘legitimate’ mandate to undertake research.

The other problems encountered related to measurement of some variables with monetary values. Because of the hyperinflationary environment that prevailed in Zimbabwe, it was difficult to establish inputs or outputs in Zimbabwe dollar as the value of the currency changed very rapidly¹³. In that regard, the study used other measures such as what the money could buy at a particular period.

The deteriorating macro environment resulted in high staff turnover in many organisations, both private and public, especially schools and clinics. The effect was loss of institutional memory in those organisations. In that regard, the researcher relied on periodic monitoring and evaluation reports for historical accounts. At Shumba clinic, the oldest serving member of staff had only been at the clinic for less than three years. For the earlier period on the clinic’s operations the researcher relied on a nurse who was local and had worked at the clinic for over twenty-five years and retired four years earlier.

3.7 Conclusion

One hundred and seven in-depth interviews were held with respondents from two purposefully selected case communities. Over sixty respondents at village level were female. Fifteen community focus group discussions were held covering special categories

¹³ In August 2006, the Reserve Bank of Zimbabwe revalued the Zimbabwe currency by removing three zeros.

such as the youth, men and women. The researcher got informed consent from all participants.

Narrative and discourse analysis based on membership categorization device was the main method of analysing the data collected. The main unit for data analysis was the community with the household and the individual as the embedded units. The SPSS was also employed to create simple descriptive statistics like frequencies from the post-coded questionnaire.

University Of Cape Town

University Of Cape Town

CHAPTER FOUR: LITERATURE REVIEW

4.0 Introduction

This Chapter explores scholarly writings on state delivery failure and the individual and community responses to such failures. The chapter is divided into five sections. The first section reviews literature on the rationale for state involvement in the provision of public goods. It traces the structures and institutions for the production and delivery of public goods in the health and education sectors in Zimbabwe. The second section explores the nature of service delivery failure. Based upon contemporary literature, the section also explores the declining capacity of the Zimbabwe state to deliver public services. The third section reviews literature on the individual and community responses to the decline in state service delivery. The fourth section reviews how Zimbabweans have responded to previous calamities and crisis and whether these long-standing coping strategies could be relevant in dealing with the 2000-2007 crisis. Section five reviews the role of class interests and power in promoting class and individual interests. The section analyses the tension between individual and collective interests.

4.1 Discourses on State Provision of Public Services

Among the main functions of governments is the provision of services and goods that for a variety of reasons the private enterprise is not able to produce efficiently. Traditionally, states provide 'public goods' and 'common pool goods and services' to citizens and deal with 'public bads' in a proactive manner. The most identifiable characteristics of public and common pool goods are that they have low excludability. Low excludability entails that it is impossible or difficult to efficiently control and prevent the harvesting of a resource or enjoyment of a service or good by any citizen or group. Public goods and common pool goods are distinguishable by the level of rivalry, with public goods having low rivalry and common pool goods having high rivalry. Low rivalry entails that citizen A's enjoyment of a good or service will not affect citizen B's enjoyment of the same good or service. High rivalry means that one person's enjoyment of a service or good subtracts from the aggregate amount available and tends to increase harvesting and access costs for other citizens (Ostrom 2005, 79).

Because of these defining characteristics of low rivalry and non-excludability for public goods, there arise specific challenges. Ordinary citizens, households and business enterprises take individual actions to maximize benefits and such actions do not necessarily add up to group rationality (Ferrori 2000, 2). Individuals are unwilling to finance the provision of public goods for fear of subsidizing those who shirk and in the hope that someone else will, despite individual rationality, be 'unreasonable' and provide the goods giving those shirking a "free ride". Free riders are actually rationally maximizing individuals and shirking permits them to apply their incomes to other consumptions, thereby maximizing their welfare. Due to the free rider challenge, the market cannot set prices to efficiently produce and allocate public goods and the returns in such investments by private concerns is necessarily low (Ferrori 2000, 2; Bailey 1995, 31).

The size of the community has an effect on the nature and extent of the free rider problem. In small communities that share common cultural values, it is often easy to develop and enforce rules. In small communities as opposed to larger ones, monitoring and sanctioning costs are low due to increased voluntary compliance as it is important for members of such communities to maintain their reputation (Ostrom 2005, 27; Putnam 1993). Due to the non-excludable nature of public goods, there is high demand for such goods. In that context, one of the viable options is to fund the provision of such goods through compulsory taxation (Bailey 1995, 31). Public goods if not provided by the state or other public body will therefore tend to be produced in inadequate quantities and sub-optimally whilst common pool goods are invariably overexploited.

Outside state control 'public bads' like environmental pollution and contagious diseases potentially increase unabated (Ferrori 2000, 6). Public policy and ultimately the provision of most public goods aim at mitigating the impact of 'public bads'. Access and the enjoyment of public goods is not however universally equitable. Citizens who for instance own motor vehicles can potentially have greater access and enjoyment of motorways than those citizens who do not own vehicles.

Private goods on the other hand are distinguishable by the characteristics of being highly excludable and rival in nature (de Mesquita *et al* 2003, 29). The rival nature and excludability of private goods make them amenable to production and allocation by private enterprise via the route of market forces.

The public provision of goods is also necessary to avert market failures. Despite achieving Pareto efficiency, the market left on its own could still fail to provide services to the most vulnerable members of the community (Stiglitz 1988, 288). In the event of market failure, the response would be a specific egalitarian public policy such as availing education and health services to all citizens irrespective of the beneficiary's ability to pay for such services.

The provision of most goods, both private and public, involves externalities. An externality involves a product having an effect on other parties other than the purchaser (Bailey 1995, 32). An externality occurs when those actions by A that have an effect on B for which there is no compensation to B if injured or benefits to A if B enjoys (Ferroni 2000, 8). The solutions to the problem of externalities would be compulsion, improving information availability or introducing a subsidy that would raise consumption to optimal levels (Bailey 1995, 28).

Firstly, the state authority could use compulsion and make consumption of goods such as primary education compulsory. The second option is for the public sector to subsidize the production and distribution of such goods in order to reduce the prices to optimal levels. There are special challenges with subsidies for once introduced they are politically difficult to remove (Bailey 1995, 36). Beneficiaries quickly consider subsidies as an entitlement resulting in them remaining in force well after the situation that demanded their deployment no longer exists. The deployment of subsidies and compulsion to attain optimal consumption levels of education and health are not mutually exclusive. A common phenomenon is that the state simultaneously subsidises education and health services at the same time requiring their consumption to be compulsory.

The state could also provide public goods as guided by the merit goods theory. The tenet of the merit goods theory is that though citizens are the best judges of their own welfare, they occasionally tend to undervalue benefits and risks arising from consumption of certain goods and services (Bailey 1995, 28). Undervaluing of benefits leads to underinvestment in areas such as health insurance as citizens underestimate the risks and costs associated with ill health (Bailey 1995, 28). Therefore, governments can be paternalistic, intervening to cause consumption or stop consumption of particular goods and services on the basis that citizens do not always know or act in their best interests. The government intervenes to coerce citizens to act in their own interests. Based on paternalistic reasons governments can introduce compulsory schooling (Stiglitz 1988, 289). A paternalistic government will also provide other services such as antenatal care and medical care for the aged and the indigent.

Education and health services generate externalities that justify government intervention. Even when the private and non-government sectors provide education and health services, they retain the essential characteristics of 'publicness', which invites the need for government to regulate their provision. Central government regulation ensures minimum safety standards, availability of services, acceptable quality and outputs, an acceptable tariff regime and indeed the politics of national identity (Bailey 1995, 11; OECD/DAC 2008, 19).

Despite the demonstrated need for the public provision of certain types of goods and services, there is always a moral hazard associated with state provision of the public goods as demands for such goods and services approaches infinity if consumers do not contribute towards the costs (Stiglitz 1988, 299). The state therefore has an irreducible role, "in choosing, designing, allocating and regulating essential services such as education and health care" (OECD/DAC 2008, 17). In Zimbabwe, central and local governments have played a dominant role in the provision of services such as education and health (Kaseke 1998, 255; GoZ 1997, 7).

Education Structure in Zimbabwe

Education in Zimbabwe is divided into five progressive levels namely, pre-school, primary school, lower secondary, higher secondary and tertiary (CSO 2001, 1). Administration of education for pre-school, primary and secondary is the responsibility of the Ministry of Education, Sport and Culture whilst tertiary education is the responsibility of the Ministry of Higher and Tertiary Education.

Pre-School Education

This is the lowest level that caters for children between the ages of three and five (CSO 2001, 1). Preschools are in the forms of nursery school, crèches and play centres. Local authorities, faith-based organisations, private organisations, individuals and communities operate the majority of pre-school institutions (CSO 2001, 1). Preschools registered with the Ministry of Education become eligible to receive grants from central government. However, few are registered and hence the full responsibility of financing them falls with the parents. Table 4.1 shows the registration status of preschools from 2000-5. There are differentiated standards in pre-school education with a majority in the urban areas, charging high fees and providing a better service whilst a few provide an inferior service in the rural areas.

Table 4.1: Registration of Preschools for period 2000 to 2005 in Zimbabwe

Status	Year					
	2000	2001	2002	2003	2004	2005
Registered	3353	3421	3725	3115	3480	3115
Unregistered	4916	4123	4669	4716	4888	4716
Totals	8269	7544	8394	7831	8368	7831

Source: Ministry of Education, Sport and Culture 2008.

No more than 40% of all preschools were registered with the Ministry of Education, Sport and Culture and were therefore eligible for grant transfers from central government. Pre-schools face challenges of attracting and retaining qualified personnel. Teachers staffing them generally lack the requisite training and skills (Nziramasanga 1999, 48).

Primary Education

This is the level after pre-school and caters for children between the ages of 6 and 12 (CSO 2001, 2). Primary Education became compulsory with the enactment of the Education Act of 1987. Up to 2004, primary education was a seven-year cycle from grade one to seven. From 2005, it became an eight-year cycle starting from grade zero to seven. However, due to the difficulties and the inability of the responsible authorities and the Ministry of Education, Sport and Culture to provide adequate infrastructure for the establishment of grade zero, most learners are admitted into grade one without having gone through grade zero. All primary schools have an establishment for grade zero though a minority has teachers either qualified or not for those classes. As a compensatory measure, government designated most registered preschools as satellite schools of existing primary schools for purposes of teaching grade zero pupils.

Pupils in primary schools take public examinations after the eight-year schooling cycle. Though the Ministry of Education, Sport and Culture's policy encourages automatic promotion to secondary schools, most high-fee paying secondary schools use the Grade seven results for determination of entrance into secondary school preferring the better performing candidates (CSO 2001, 2; Singleton 2006, 46). Individuals, not-for-profit organisations, local authorities, government and private enterprise particularly mines and farms can operate primary schools as shown in Table 4.2.

Table 4.2: Primary Schools by Responsible Authority and Province in Zimbabwe in 2004.

<i>Province</i>	<i>Church/ Mission</i>	<i>City Council</i>	<i>Rural District Council</i>	<i>Farm</i>	<i>Government</i>	<i>Mine</i>	<i>Town Board</i>	<i>Other</i>	<i>Total</i>
Harare	8	37	1	1	117	0	5	39	208
Manicaland	57	5	638	51	17	0	0	39	807
Mashonaland Central	14	4	290	42	5	6	0	10	371
Mashonaland East	27	2	479	44	7	2	2	19	582
Mashonaland West	25	10	335	48	29	14	8	20	489
Masvingo	33	6	595	17	7	4	11	7	680
Matebeleland North ⁽¹⁾	26	28	411	1	70	4	10	22	572
Matebeleland South	19	0	388	2	8	3	1	19	440
Midlands	29	12	553	13	29	11	3	2	652
Total	238	104	3 690	219	289	44	40	177	4 801

Note ⁽¹⁾ Including Bulawayo

Source: Ministry of Education, Sport and Culture 2008.

Local authorities particularly the Rural District Councils administer the majority of the primary schools: 3690 out of 4801¹⁴.

Lower and Higher Secondary Education

Secondary education in Zimbabwe has two levels, lower and higher. The lower secondary phase is a four-year cycle leading to ordinary level¹⁵ examinations and caters for pupils from the age of thirteen (CSO 2001, 2). High schools use the ordinary level examination results as the basis for entry selection into advanced level and a few learners qualify for advanced studies (CSO 2001, 3). Higher secondary is a two-year course that leads to advanced level examinations primarily used for university entrance. Table 4.3 shows the distribution of secondary schools by responsible authority and province.

Table 4.3: Secondary Schools by School Authority and Province, 2004 in Zimbabwe

<i>Province</i>	<i>Church Mission</i>	<i>City Council</i>	<i>Rural District Council</i>	<i>Farm</i>	<i>Government</i>	<i>Mine</i>	<i>Town Board</i>	<i>Other</i>	<i>Total</i>
Harare	5	0	0	0	54	0	1	17	77
Manicaland	43	0	177	3	17	0	0	7	247
Mashonaland Central	16	1	80	1	10	2	0	1	111
Mashonaland East	25	2	198	2	11	1	1	5	245
Mashonaland West	11	3	116	3	17	6	3	5	164
Masvingo	17	1	176	0	29	1	1	4	229
Matebeleland North ⁽¹⁾	19	0	70	0	38	1	3	7	138
Matebeleland South	18	0	84	0	10	0	1	4	117
Midlands	32	0	185	2	14	0	4	2	239
Total	186	7	1 086	11	200	11	14	52	1 567

Note ⁽¹⁾ Including Bulawayo

Source: Ministry of Education, Sport and Culture 2008.

As with primary schools, Rural District Councils operate 69.3% of all secondary schools in Zimbabwe. Missions, farms and mines operate another 13.3% of registered secondary

¹⁴ In Zimbabwe, there are two broad categories of local authorities: Urban Councils and Rural District Councils. There are 60 Rural District Councils (RDCs) in the whole country. The Rural District Councils generally have fewer financial means than government, private sector or their urban counterparts. Section 3.1 discusses the structure of sub-national administrative institutions in more detail. The most important resources RDC have are individuals and communities who contribute labour to most of their public projects. Chapter 6 and 7 discusses in detail the roles of the individual and community in service.

¹⁵ Ordinary Level is equivalent to the Cambridge General Certificate of Education level.

schools. Government schools are located mostly in urban centres with a few in commercial farming areas and a negligible number in the communal areas.

Tertiary Education

The tertiary level constitutes postsecondary school training, universities, technical, agricultural, teachers' colleges and apprenticeship training (CSO 2001, 3; Singleton 2006, 46). Parallel to the public sector is a private sector that provides commercial tertiary education at a cost. This sector operates independent of government and is entirely dependent on fees for income (Nziramasanga 1999, 53). The private institutions also offer foreign qualifications particularly South African and British ones.

Funding and Finance of Education

Central and local governments, private enterprise and faith based organizations, the responsible authorities for schools, parents, and guardians fund education services in Zimbabwe (CSO 2001, 5). Since independence in 1980, central government has been providing a grant for building and maintenance to all registered schools. Central government assigned the overall responsibility for the construction of school buildings, supply and purchase of building materials in rural areas to local communities that were mobilized through school development committees for non-governmental schools and school development associations for government owned schools (CSO 2001, 5). The responsible authorities charge levies in the form of the building fund and general fund fees for special projects. Government also provides a 'per capita' grant to cover recurrent costs for all pupils in registered schools (CSO 2001, 5). Furthermore, government meets the full salary costs for all approved establishment of teachers in registered schools, be they government or non-government (Singleton 2006, 46).

Health

The central government policy is to concentrate on primary health, that is, 'people who are ill should be treated close to their homes as much as possible in the smallest, most humbly staffed and most simply equipped unit' (Gilmurray, Riddell and Sanders 1979, 47). In terms of policy, a network of 6000 village health workers (VHW) established in

1981 supports primary health (Singleton 2006, 53). The VHWs initially established under the Ministry of Health and Child Welfare, but when transferred to the Ministry of Community Development, Cooperatives and Women's Affairs was renamed village community workers. The transfer blurred their functions and subsequently reduced their effectiveness.

Central and local governments, the private sector, faith-based organisations, mostly Christian missionaries, operate health institutions (Singleton 2006, 53). The health delivery system in Zimbabwe falls into four levels that operate as a referral chain (Singleton 2006, 53) as shown in Table 4.4.

Table 4.4: Distribution of Health Facilities Levels in Provinces

<i>Provinces</i>	<i>Primary level</i>	<i>First referral level</i>	<i>Second referral level</i>	<i>Third referral level</i>	<i>Total</i>
Bulawayo	34	0	0	7	41
Harare	45	0	0	7	52
Manicaland	253	36	1	0	290
Mashonaland Central	130	13	1	0	144
Mashonaland East	168	22	1	0	191
Mashonaland West	128	22	1	0	151
Masvingo	170	23	1	0	194
Matabeleland North	92	17	0	0	109
Matabeleland South	105	18	1	0	124
Midlands	206	28	1	0	235
TOTAL	1331	179	7	14	1531

Source: Zimbabwe Central Statistical Office 2008.

Primary level institutions are the rural health centres and local authority clinics staffed by nurses and specialising in the provision primary health care. The first referral level consists of district, mission and rural hospitals. The first referral institutions are by regulation staffed by medical doctors but are usually under the charge of senior nurses. The second referral level consists of provincial hospitals. Central teaching hospitals and infectious diseases control hospitals constitute the third and highest referral level. All third referral level hospitals are located in the two largest cities of Harare and Bulawayo.

Though the mission hospitals are private, they operate on the principle of nonprofit and are overly reliant on central government funding for their operations (Singleton 2006, 54). The profit oriented private operators have remained largely concentrated in the urban centres (Singleton 2006) and became significant actors in the wake of the decline of the health delivery in the public sector. Singleton (2006, 53) records that the National Health Accounts indicates that 36.3% of people seeking health care go to government facilities, 26% to local authorities health facilities, 19% access private facilities 9% get service from missions, 5% go to traditional leaders and the remaining 4% rely on faith healers.

4.2 Discourses on State Delivery Failures

The Incapacities of the postcolonial State in Africa

The state (in Max Weber's sense) as a sovereign entity with the monopoly of legitimate coercion in a territorial space is a recent phenomenon in Africa having only emerged following the decolonisation wave that began in the 1950s.

The studies of the postcolonial states in Africa have generally portrayed a picture of weak, struggling and autocratic regimes (Englebert 2009, 1; Bates 2008; Collier 2007, 3; Rotberg 2004; Trefon 2004, 3; Reno 1998, 2; Moyo 1992, 82; Herbst 1990a, 1; Jackson and Rosberg 1982, 1). Jeffrey Herbst (1990a, 1) characterises African states as being "extremely vulnerable because they are disorganized and poor, and because they face societal groups that have the potential to mobilize large numbers of people or great economic resources". Many scholars have attributed the delivery failures of the African state to causes beyond the actions of individual leaders and government policy (Azarya and Chazan 1998, 4). Moyo (1992, 80), ascribes the weaknesses of the African state to three factors: colonial heritage, mode by which independence was delivered and the post independence challenges. The African states typically inherited state structures (including security and civil service) designed to cater for the colonial minority and essentially unresponsive to the majority. Since there was no revolutionary takeover of the state, the new independent governments maintained the inherited structures (Moyo 1992, 80). After independence, the rivalry between many ethnic groupings continuously threatened the unity of the new state, generally eroding checks and balances (Rothchild and Chazan

1988, ix). The main aim then became one of maintaining the unity of the new state as one entity. The attainment of that objective usually came at the cost of intolerance to dissent (Moyo 1992, 82). The entrenchment of personal rule prevented the establishment of independent constitutional and institutional offices in most of Africa (Jackson and Rosberg 1982, 7).

Despite being weak, the state still played a critical role in African politics, for “while the state in Africa may have relatively few resources, it generally operates in an environment that is so materially deprived that the sphere outside the public sector is even poorer and provides few, if any, opportunities for economic advancement” (Herbst 1990a, 1). When the state in Africa fails to deliver public services there will therefore be greater deprivations affecting large sections of society.

Most of sub-Saharan Africa has failed to deliver essential health services to their population and “health services have all but collapsed in many countries as a result of the HIV/AIDS epidemic” (Crowe 2006, 27). The sub-Saharan region carries the heaviest burden of the human immuno virus and the acquired immune deficiency syndrome (HIV/AIDS), malaria and tuberculosis (TB) (Crowe 2006, 25).

The labelling of states unable to deliver public services to a majority of their citizens has been a subject of contestations in recent scholarship. Scholars refer commonly to such states as fragile, failed and collapsed (Bates 2008; Rotberg 2007; Zivetz 2006, 1; Hough and du Plessis 2004; Rotberg 2004; Doornbos 2003; Milliken and Krause 2003; Herbst 2000; Herbst 1996; Zartman 1995). However, scholars informed by the postcolonial discourses, dismiss such labels as being Eurocentric and using the Weberian model of state as the ideal which independent states should aspire to be and indeed measured against in terms of the their statehood (Trefon 2004, 3; Hill 2005). The postcolonial scholars contest the continued use of the Weberian model as a standard measure for newly independent states and argue that it is inappropriate and designed to maintain the hegemony of former colonizer over the former colonies. This debate is beyond the scope this study. However, of relevance is that a number of states gaining independence after

1950 in Africa are unable to discharge some essential services to the majority of their citizens (Englebert 2009; Williams 2006, 37).

Recent scholarship (Englebert 2009, 4; Collier 2007; Collier and Hoeffler 2004; Menkhaus 2003; Reno 2000) argues that state weaknesses in meeting obligations persist because of greed as particular elements in a society reap economic benefits from the emergency created by the state's inability to deliver essential goods and services. Such an emergency presents, "an opportunity for profit, not a crisis to be solved" (Menkhaus 2003, 406). Furthermore, the local populations come to view the state and its institutions as tools for appropriation and hence have become sceptical of politics and are not willing to invest in state reconstruction (Menkhaus 2003, 409).

There have been four main responses to the inability of the state to deliver public services (Williams 2006, 40). The first type of response involves external assistance for a state to regain control over its territory. The second type of response involves the international community assisting the states to provide essential public goods. International responses to health emergencies in sub-Saharan Africa involved setting up the Global Fund to Fight Aids, TB and Malaria following the group of eight (G-8) summit at Okinawa Japan in 2000 (Crowe 2006, 27). The sub-Saharan governments responded to the emergency by committing to allocate at least 15% of their national budgets to health in terms of the Abuja commitments, a substantial number of countries including Kenya, Tanzania and Uganda initiated policies to decentralise health, and make services accessible to previously disadvantaged rural communities.

In Africa, NGOs in partnership with the private sector have performed a significant role in funding and delivery of national health initiatives (Crowe, 2006, 28). NGOs are not-for-profit organisations and have grown to be trusted by citizens due to "public faith in altruism as their only motivation" Robert (2002, 351). When governments fail to deliver, the 'burgeoning of activities by NGOs' and other voluntary groups increasingly take up the power and service vacuum left by the weakened state (Englebert 2009, 3; Francis and Amuyunzu-Nyamongo 2005, 12; Trefon 2004, 4). In a now seminal study of warlords

and states in Africa, Reno (1998, 10) argues that global non-state actors form alliances with weak postcolonial state rulers and increasingly take up the roles of weakened local bureaucracies. In Zimbabwe, the role of faith-based organisations (FBO) in the form of missionaries is long-standing from pre-colonial times having established the earliest and in some cases the only health and education facilities until independence.

The third kind of response which is rare, entails permitting the state to disintegrate (Englebert 2009, 1). The fourth response is from local indigenes and is varied in nature. Some citizens have sought to resurrect the state capacity and enjoy the benefits from international aid whilst others adopted accommodation strategies (Williams 2006, 41) bypassing the state and engaging in ‘alternative forms of intercourse’ including associating with religious groups and migration; strategies that have little respect for existing political authority and borders. Local people also responded through protest and grassroots mobilisation against poorly performing regimes (Englebert 2009, 2). In Somalia, groups continued an existence despite lack of central authority and became suspicious of any attempt to revive the state (Williams 2006, 41). In the Democratic Republic of Congo (DRC), the communities compensated for the failures of the state to provide public goods by ‘reinventing order’ out of the disorder. The communities generated multiple strategies and created a new order, “based on the combination of global and local approaches and on the intermingling of traditional cultural systems and practices with new forms and perceptions of modernity” (Trefon 2004, 2).

The ‘Hollow State’

The hollow state is a metaphor to characterize those states that have failed in discharging their mandate but retain their legal statehood status and international recognition. Herbst (2000) aptly traces the origin and character of the hollow state. The 1884/85 Berlin Conference established territorial states from institutions that were not necessarily able to exercise physical control over their territories, particularly the hinterland. The sanctity of colonial state boundaries confirmed by the postcolonial African leaders at an Organisation of African Union (OAU) heads of state meeting in Addis Ababa in 1964 still prevails (Englebert 2009, 32; Williams 2006, 38).

The international community guarantees the territorial integrity of even those states that are unable or unwilling to provide basic services to their citizens. Even in cases where neighbours and foreign powers intervene in an emergency resulting from the state inability to discharge essential functions, such an intervention is never to alter the state boundaries (Jackson and Rosberg 1982, 20). The primary objective of external intervention is to “effect the balance of power (as in the DRC) or take advantage of economic opportunities presented by failure (as in Liberia) but the formal boundaries of the state will continue to be recognized by all concerned” (Herbst 2004, 309). Therefore, among the African states some could not effectively exercise power throughout their territories. These states could not establish and maintain essential infrastructure and services such as a road network and viable currency in areas outside the capital. Such states are ‘hollowed out’ and Herbst (2004, 10) characterise them as representing no more than mere “geographic expressions”. In the same vein, Barak (2005) posits that such weak states are artificial creations and essentially “hollow juridical shells”. A number of African states have maintained jurisdictional persistence in the face of empirical weakness (Jackson and Rosberg 1982, 1).

The hollowed out states create a power and service provision vacuum taken up by contending local groups. Barak (2005), observes that the local actors in ‘hollow states’ attract the sympathies of contemporary foreign “Robin Hoods”.

Zimbabwe: An assessment of its capabilities

Despite the growing consensus that the economic situation in Zimbabwe has deteriorated drastically from 2000 (Raftopoulos and Mlambo 2009; Hammar, Raftopoulos and Jensen 2003; Sachikonye 2002), there is no agreement as to whether Zimbabwe entered an emergency as a direct result of the failure to deliver the essential services. In a Freedom House study of 30 countries in decline, Zimbabwe is classified as one of the countries, “that qualify neither as failed or as clear beacons of democracy” (Tatic and Walker 2006, 1). The Freedom House (Tatic and Walker 2006, 3) evaluates the performance of selected

countries on four main criteria, namely public voice and accountability, civil rights, the rule of law, anti-corruption and transparency. The Freedom House scores are provided in Appendix L.

Of the thirty countries surveyed, Zimbabwe received the lowest scores in three of the four areas and second lowest in the fourth category. A score of 5.00 is the basic standard of effective performance. The lowest score by any country on a variable was by Zimbabwe 0.88, on the existence of laws and standards to prevent and combat corruption and government ability to enforce these. The issue of corruption where the leadership is concerned about maximising personal gain at the expense of public service delivery is particularly critical in countries where the majority of the people rely on the public sector for the delivery of most of their fundamental needs (Tatic and Walker 2006, 3). In situations of the high prevalence of corruption as in Zimbabwe, “entrenched corrupt networks feed on weak and insular state institutions that were designed to deliver political goods to the public” (Tatic and Walker 2006, 3). In any country, the media is critical in reporting government actions, corruption and serving the public interest as it provides space for the public voice. However, the Zimbabwean government used violence and intimidation to harass journalists who opposed or failed to support government actions and policy (Tatic and Walker 2006, 6). Citizens cannot be guaranteed security and public order due to the compromised independence of the judiciary. The Freedom House scores demonstrate the Zimbabwean government’s inability to deliver key services in the areas of security and public order, representation and welfare.

In terms of the *Foreign Policy* ranking of states failing to deliver key services to its citizens Zimbabwe, as shown in Table 3.5 is one of the worst performing countries since the inception of rankings in 2005.

Table 4.5 Failed States Index Rankings for Zimbabwe 2005 to 2008

Year	Score Maximum =120	Country Ranking, Number 1 being the worst	Number of Countries Assessed	Number of Countries Ranked Worse
2008	112,5	3	177	2
2007	110,1	4	177	3
2006	108,9	5	148	4
2005	94,9	15		14

The ranking published in a particular year are based on data collected for the previous year. For example, 2005 ranking is based on 2004 data and 2008 ranking on 2007 data.

Source: Foreign Policy, Failed States Index Ranking Reports for 2005, 2006, 2007 and 2008, <http://www.foreignpolicy.com> accessed 7 August 2009.

The *Foreign Policy* magazine States Indexes based its assessments on twelve social, economic, political and military indicators. The compound index measures the vulnerability to internal conflict. Information for the assessments was based on data from publicly available sources. In the first ranking of 2005, Zimbabwe was one of the poorly performing countries ranked 15. In 2006, it slid to number five and steadily deteriorated by one position each succeeding year reaching a low of three by 2008¹⁶.

The Zimbabwean state retained the monopoly over use of violence and authority over its territory but increasingly failed to deliver on public services to all citizens. The Zimbabwean state failed to deliver key services by choice as Williams (2006, 38) argues, “Robert Mugabe’s ongoing manipulation of ZANU-PF and state power in Zimbabwe is the paradigmatic example of a regime choosing to deny basic rights to certain segments of its population in an attempt to bolster security”. It follows therefore that there are segments of society that might benefit from the emergency created by the non-delivery of public services.

There are two main schools of thought explaining the causes of state incapacity in Zimbabwe. One school contends that it was an outcome of the clash between the nationalist, revolutionary forces in defence of sovereignty as represented by ZANU-PF government and its functionaries against the ‘imperialist’ West as represented by the

¹⁶ The 2009 Foreign Policy ranking indicated that Zimbabwe had slid further into number two, only doing better than Somalia.

former coloniser, the United Kingdom and its main ally the USA. This school argues that the West imposed sanctions on Zimbabwe in retaliation for ZANU-PF led government's land reform that took away land from the white Western countries' 'kith and kin'. The ZANU-PF led government politically constructed the takeover of white-owned farmland as justified and long overdue to redress a colonial imbalance. The withdrawal of external support and imposition of 'illegal sanctions', were therefore the main causes of the decline in state delivery capacity and not the internal policies and governance style of the ZANU-PF government (Mamdani 2008; RBZ 2008). The government of Zimbabwe persistently and consistently traced the origins of the atrophy in the economy to the 'illegal sanctions' imposed by the former colonizer Britain and her American and European allies (RBZ 2008, 97).

The contending school of thought traces the origins of the Zimbabwean crisis to ZANU-PF's policies in government (Raftopoulos and Mlambo 2009; Scarnecchia, Alexander and 33 others 2009; Collier 2007; Rotberg 2007; Ranger 2005; Hough and Du Plessis 2004; Daronlf and Laakso 2003; Hammar *et al* 2003; Hill 2003; Sylvester 2003; Sachikonye 2002, 15; Baynham 1992). Tatic and Walker (2006, 5) argue that, "President Robert Mugabe has dragged Zimbabwe into a political, social and economic morass. ZANU-PF economic policies have transformed one of Africa's most diversified economic sectors into a pre-industrial peasant-based economy". The most damaging policies included the chaotic and often violent dispossession of white owned land, the accompanying breakdown of the rule of law, corruption in the reallocation of repossessed land and the ill-informed fiscal policies such as price controls. The result of such policies was economic stagnation and retrogression.

The first school of thought has serious flaws as it fails to take into account the endogenous factors. Firstly, balance of payment support should only augment recipient country's resources and any state that cannot survive outside external non-humanitarian support may be too weak or have inappropriate policies to sustain itself. Secondly, the withdrawal of donor balance of payment support was principally in response to Zimbabwe's inability to meet its debt obligation and hence it was essentially a technical

decision. Technically, the World Bank and International Monetary Fund cannot continue lending a non-complying client. Thirdly, the ‘illegal sanctions’ were selective, targeted at the top leadership of the ruling ZANU-PF party. The government faced no hindrances in trading with its major trading partner South Africa or other major economies such as China and Russia. The aggressive foreign policies by a few unfriendly countries are so common that they cannot account for the Zimbabwean crisis. This study concurs with the position that the crisis in Zimbabwe was mainly a result of corruption, failure to embrace democratic reforms and public policies that committed the government beyond its financial means.

4.3 Coping Strategies

Coping involves individual, household or the community making cognitive and behavioural adaptations when confronted with change producing events (Marotz-Baden and Colvin, 1985, 281). Broadly defined, strategy refers to activities aimed at satisfying physiological, social, economic and political needs of common day life (Mararike 1999, 2). Joshi and Gandotra (2006, 56) define strategy as “a continuum of adjustments made... in response to internal and external factors to survive at the same level or attain upward mobility”. Strategy implies some executed plan, employed to achieve a specific purpose. Coping strategies are therefore plans executed to deal with some life changing and often threatening event. Coping strategies operate at individual, household and community levels. Successful coping at different levels involve use of both internal and external resources (Marotz-Baden and Colvin 1985, 282). Internal resources involve use of individuals, households and community resources, including enhanced integration whilst external resources entail leveraging resources outside the unit of concern.

Individual level coping

Relations between individuals and the state vary from full incorporation to full disengagement (Chazan 1988, 125). Despite the increased incapacity of the state to deliver, individuals such as salaried civil servants continue to rely on the state as a major source of resources. The majority of individuals however disengage and only relate to the state structures in a manner that seems beneficial to themselves. Individuals respond to

the decline and collapse of the formal sector by accessing the shadow economy (Chazan 1988, 126). Increased human insecurity resulting from the decline in the capacity of the state to deliver public services leads the non-poor members of the community to relocate to safer urban settlements, depriving the exited communities of investment and voice (Francis and Amuyunzu-Nyamongo 2005, 28).

At the individual level, one viable option under pressure would be for workers to exit formal employment, “because of the high cost of staying in employment, instead preferring to engage in various informal sector activities” (Rafptopolous 2007). Individuals and groups can employ religious based coping strategies in the form of spiritual and emotional support (Krause *et al* 2001). Healing churches are often appropriate as they go further than western medicine by treating both body and soul (Persyn and Ladriere 2004, 79). A study on the DRC observed some “universal recourse to faith in the face of despair and suffering” caused by state inability to deliver services and the high incidence of poverty (Trefon 2004, 14). The response to state failure indigenised the delivery of health and education (Trefon 2004, 9). There was a shift from western medicine to syncretic faith based healing and in many cases citizens combining both traditional and modern medicine, taking advantage of the best aspects of the two systems (Persyn and Ladriere 2004, 69). In Zimbabwe, as the economic and political crisis deepened, more people turned to churches for spiritual and material support whilst the churches themselves also became more critical of the state (Muzondidya 2009, 196). Health care also changed from being a public service to a free market commodity (Persyn and Ladriere 2004, 67).

Household level coping

The household, being the smallest unit of exchange (Chazan 1988, 136) becomes critical for developing survival strategies for its members. When households and communities are under stress, they adopt individual or group based coping strategies. The group and individual strategies are complementary and mutually reinforcing. There are four major coping behaviours under stress (Joshi and Gandotra 2006, 56): decreasing the presence of vulnerability factors, strengthening family resources, that is, family cohesiveness;

adapting; reducing or eliminating stressor events and their specific hardships; and actively influencing the environment by changing the social circumstances.

At household levels, there is a range of coping strategies. As noted by Joshi and Gandotra (2006, 59) there can be:

more specific coping strategies involving a more judicious and economical use of existing resources (backward copying strategy) and/or augmenting economic opportunities and entitlements to economic resources, which minimize the presence of vulnerability factors (forward coping strategies).

Emigration becomes one of the several means of spreading risks and remittances contribute substantially to family income (Trefon 2004, 12). The household and community asset bases, cost of living, ability to generate additional income and the level of exposure and vulnerability (Joshi and Gandotra 2006, 62) will inform the choice of a specific coping strategy.

Community level coping

State inability to provide public services does not immediately translate into a situation of non-provision of state functions or the emergence of a serious political disorder. Sub-national level structures and institutions such as traditional leadership might assume an existence independent of the state and continue offering services in the case of inability of the state to deliver (Milliken and Krause 2003, 15; Chazan 1988, 127). Strong and cohesive communities can “reconstitute missing state functions” through activities of associational life or other non-state actors (OECD/DAC 2008, 14). In Kenya, Francis and Amuyunzu-Nyamongo (2005, 19) observes that rural communities filled the service gap created by the failing state services through the provision of infrastructure and personnel hired by the community. In the DRC, communities created solidarity networks to compensate for the failing state (Trefon 2004, 9). Following the demise of a central authority from 1991, the communities in Somalia, adapted to increasing insecurity by establishing ‘neighbourhood watch’ groups (Menkhaus 2003, 412).

However, lack of material resources undermined the solidarity networks as individual interests supplanted collective interests. Different communities develop unique strategies for promoting the solidarity networks. In the DRC, shirkers were persuaded to comply and rarely was violence used (Trefon 2004, 10) and in contrast, in Somalia, abductions were commonly used to ensure that defaulters redeemed their debt (Menkhaus 2003).

Rahmato (1991, 16) classifies community survival strategies into two categories, namely anticipatory survival strategies and crisis survival strategies. Communities use anticipatory strategies during normal situations and the crisis strategies in stress situations. The difference between the anticipatory and crisis survival strategies is primarily of intensity and degree, with the anticipatory strategies intensified when implemented as crisis strategies. The success of crisis survival strategies largely depends on the success of earlier anticipatory strategies (Rahmato 1991, 16). Labour migration as anticipatory survival strategy takes place all the time but increases in intensity, duration and form during the periods of stress where such strategies are “magnified or distorted by emergency conditions and the accelerated course of events” Rahamato, 1991, 16).

Rahmato (1991, 117) further identifies three phases in which rural communities of Ethiopia responded to the 1984 famine. The sequence identified by Rahmato (1991, 117) could be relevant in understanding Zimbabwean rural community reaction to calamity. The three phases of responses are crisis anticipation, crisis management, exhaustion and dispersal. Crisis anticipation is concerned with forecasting and preparing for disasters. It involves the use of traditional early warning systems. Crisis management leads to the shift from subsistence agriculture into the cash economy (Rahmato 1991, 141). The final phase of response to the crisis is exhaustion and dispersion when all local resources and survival strategies have been exhausted and the imminence of inevitable death forces the rural farmers to collectively disperse and mass migrate, ‘it is a form of the demand for the consecration of the right to life. It is a form of silent protest. Finally, mass migration is a form of escape from spectre of death’ (Rahmato 1991, 157). At this phase, the members of the community might collectively voice by taking to the streets and looting as a form of collective catharsis (Trefon 2004, 18). Some stressors such as the high prevalence of

HIV and AIDS and consequent need for home-based care is gender insensitive, putting more burden on women rather than men and in the process distorting the long-standing coping mechanisms (Francis and Amuyunzu-Nyamongo 2005, 22).

Perverse Coping

Community responses to the decline in public services are not always acceptable as judged by local morals nor are they necessarily sustainable. Coping strategies are often perverse as in cases where people facing severe privation resort to crime, asset stripping, commercial sex, child labour, reduced food intake, destitution and begging and reducing access to education and health and care (Trefon 2004, 10). Because of resource constraints, people delay seeking medical attention until they are seriously ill (Persyn and Ladriere 2004, 73).

Pressures on communities do not always lead to pathological stresses but survivors could adapt and actually generate more viable coping mechanisms as groups might be “able to cope with widespread danger and disaster, to maintain rational and adaptive problem solving behaviours, and even to use the experience as a source of renewed strength” (Suedfeld 1997). In compensating for the failures of the state, the communities become adaptive, creative, and inventive (Trefon 2004, 9).

4.4 How Zimbabweans Coped with Previous Crises

Throughout the colonial and postcolonial periods, Zimbabweans faced a series of national crises. The coping strategies generated to cope with the challenges become the basis of dealing with misfortunes later. The adjustments to colonial rule and land disposition were major crisis that the rural farming communities of Zimbabwe encountered. The responses to those crises inform the future responses to the decline in public services. When faced with the reality of colonial conquest and the imposition of foreign rule, the locals did not flee in the framework suggested by Herbst (1990b) but remained steadfast, protested and fought to drive out the occupier. When the voice against the colonialist failed to recover the situation, it turned into armed struggle, in 1893, 1896-97 and 1964 leading to independence from colonial rule in 1980. The second phase of the protest

combined both exit from the system and sustained protest via the armed liberation struggle.

Land dispossessions and the fall in crop prices in the early twentieth century led to ‘self peasantisation’, that, “involved the deliberate and painful adoption of a number of strategies designed to maximize the potentials of peasant production; strategies which meant important innovations in division of labour, in staple crops, location of residence and subsequently in technology and ideology” (Ranger 1985, 31).

Even prior to colonization, when faced with economic misfortune, the communal areas farmers of present day Zimbabwe resorted to migrating to the gold mines in South Africa for employment. After colonial occupation in 1890, short-term labour migration to the urban areas and mines opened in Rhodesia supplemented and substituted longer trips to South African gold mines (Davis and Dopcke 1987, 67). In the 1920s, the one-year to three-years sojourns to South Africa were still common, designed to meet long-term obligations such as marriage or capital accumulation whilst short-term migration trips satisfied needs for tax obligations or ameliorated shocks induced by crop failure and droughts (Davis and Dopcke 1987, 69). The long-term trips to the South Africa were not permanent exits but strategies to augment domestic rural economy. From the early twentieth century, the male labour migration in Rhodesia became the ‘rite of passage; a mark of manhood’ (PRF 2003, 35).

The Witwatersrand Native Labour Association (Wenela) constituted by South African mines to recruit migrant labour operated through bilateral agreements between governments and remittances benefited the public sector (The Zimbabwe Independent 2009, May 7). Zimbabwe among several southern African countries was a major contributor of migrant labour through Wenela. Whilst South Africa was a regional attraction for labour there was also substantial movement from Northern Rhodesia and Nyasaland to Southern Rhodesia especially during the Federation era between 1953 and 1963 (Barnes 2002, 164). However, due to the nature of the modern state and boundaries,

it is increasingly difficult except for a few highly skilled personnel to migrate and legally settle in foreign countries (Herbst 1990b, 184).

In Rhodesia, migration to South Africa was also common in search of post primary and higher education. The first government high school in Rhodesia was only established in 1946 and the University in 1957, and consequently initial black university graduates were educated at South African universities (Barnes 2002, 171). Education was an upward mobility tool available to the African in a racially segregated administration (Barnes 2002, 170).

Historical evidence indicates that African women registered formidable presence in the urban, mining and farming communities having migrated from the communal areas in search of enhanced opportunities (Barnes 2002, 164). From 1980, women in Zimbabwe played a major role in short-term cross-boarder trade in neighbouring Botswana and South Africa (PRF 2003, 11). The movement of women from the rural areas to the urban areas and across borders was contrary to the dominant endocentric migration paradigm that treated migration as men's role with women depicted as compliant 'defenders' of rural homes. Women in Zimbabwe were active and consciously migrated from rural areas for better opportunities in the urban, mining and farming areas (Barnes 2002, 170).

Migration can be construed as an individual decision to deal with personal misfortunes and a strategy for capital accumulation with proceeds at the full disposal of the individual migrant. Migration might also be a family coping strategy. Most rural families in Zimbabwe cannot fully subsist on farming due to the variability of rains and the volatility of agricultural markets and hence have to diversify income sources through the export of family labour. The migrant is then obligated to remit part of their earnings to rural-based family members who in turn view the remittances as entitlements received in exchange for releasing the migrant from farm labour. In a study in western Zimbabwe where labour migration into South Africa and Botswana had been one of the main forms of survival for generations, it was established that families of migrant workers in Zimbabwe expected

remittances on a regular basis as a matter of entitlements and felt aggrieved if they did not (Maphosa 2005, 8).

Migration is also age sensitive. Bates (2008,79) posits that due to the high costs of migration, the younger rather than the older generation is more likely to migrate from overcrowded lands, “for the younger generation can amortize the costs of migration over a longer stream of earnings”. However, as the younger generation lack relocation costs, they rely on older generation for sponsorship and the ‘gerontocratic political institutions’ ensure that the older generations continue to have access to earnings of the younger generation who are obliged to repay the earlier investment by the older generation (Bates 2008, 79).

In post-independence Zimbabwe, rural communities endured hardships brought about by the implementation of the economic structural adjustments programme from 1991 to the turn of the century. Mwanza (1999, 52) identifies a number of coping strategies that were commonly used to deal with stresses in the education and health sectors. In education, there was a marked increase in the transfers of children from rural to urban schools perceived to offer better facilities. Many families accessed assistance from government through the social dimension of adjustments, a programme designed to ameliorate the negative impacts of the economic structural adjustment. Some vulnerable families also relied on transfers from relations to meet school fees obligations.

In a sociological study on survival strategies of rural villagers in Eastern Zimbabwe Mararike (1999, 2) posits that the village people in Zimbabwe relied on three resources to survive adversity. The three resources were: control over assets; use of indigenous knowledge; and access to viable organisations. Assets are the in/tangible stores of values or claims of assistance potentially mobilized for survival (Mararike 1999, 2). Knowledge refers to the use of information about the local environment as a system of beliefs and concept whilst organisations are the social structures that promote or inhibit the allocation, control and access to local assets and the use of knowledge (Mararike 1999, 3).

4.5 Power, Class and Interest

Power, as the capacity to control resources (Chazan 1988, 123) is common in all human societies. There are tensions between individual and class interests and the collective community interests. Of particular interest is how different classes use power to further interests. There are two main approaches to social classes, the Marxist or the social science approach (Robert 2002, 76). The Marxists view all developments as fundamentally based on class conflict with the ultimate conflict between bourgeoisie and proletariat leading to a classless society in the communist stage of development. Relations of production determine class with the ruling class controlling the means of production. The alternative formulation of class is based on observation as opposed to the theoretical Marxist view. “Social status, wealth and income and structural aspects of the economic location of the individual” determine class (Robert 2002, 76).

There are different classes with different interests and varying access and links to state power. There is also increasing recognition that the state is no longer the sole repository of power as subnational structures, “maintain an institutional and resource base which permits them to act independently as well as conjointly with structures in the public domain” (Chazan 1988, 123). Interests are rooted in experiences of class; race, gender and poverty (Ledford 2006). Classes are therefore not monolithic formations as distinctions based on power and income exists within and across class boundaries (Ledford 2006). Power defines class such that there could be differences in income within a class but with people in the same class having similar access to power.

Though having common concerns, rural farmers are not one monolithic grouping. The main distinguishing features of different groups in rural areas are: access to off-farm income; access to land; and ownership of assets such as cattle (Mararike 1999, 2; Pankhurst 1988, 3; Leys 1986, 260).

Remittances are a significant source of off-farm income for rural households (Maphosa 2009, 33). There is increasing heterogeneity in communal area farmer class owing to differences in access to transfers and “there are even indications that social inequality is more pronounced in the communal areas than it is within the entire black population of

Zimbabwe” (GTZ 1999, 16). Differences based on income and consumption are exhibited by the varied access to private schooling and medical care (Francis and Amuyunzu-Nyamongo 2005, 19). Inequality is also gender sensitive with female-headed households more likely to be poorer than the male-headed households (GoZ 2006, 4). There can also be differences in access to resources within the household.

In classifying rural households the study adopts the classification criteria employed by Pankhurst (1988, 3) in a study of rural communities in Murewa District, Mashonaland East province of Zimbabwe, located in agro-ecological region two. Leys (1986, 263) had similar categorisation of rural households in a study in semi-arid district of Chivi in southern Zimbabwe. The categorisations were instructive, as the two cases in this study were located in similar agro-ecological regions two and four. Pankhurst (1988) identifies four sub-groups, but the study found no substantive differences in two of the groups and collapsed them into one hence the study identified three distinct groups among the rural households. The groups are categorized by the amount of off-farm income they access, level of asset ownership; all factors that are correlated to the structure of the household. During the peak farming season, farmers use off-farm income to purchase labour, procure agricultural inputs, implements and pay for medical and education expenses. Significant sources of off-farm income are remittances from relatives in urban areas and the diaspora, trading and selling of labour in rural areas. Remittances can be in the form of cash or commodities (Maphosa 2005, 4; Pankhurst 1988, 9). Households with access to essential commodities in short supply such as soap, cooking oil, lighting paraffin, agricultural seed, fertilizers gained significant power as they exchanged these for labour and other social favours.

The first cluster identified as Group 1 by Pankhurst, this study classifies as non-poor category of communal farmers. The non-poor households have access to regular off-farm income. The off-farm income is mostly in the form of remittances from a family member in urban areas within Zimbabwe or the diaspora. The non-poor also contains what Leys (1986, 263) terms the ‘rural salariat’ comprising of teachers, medical personnel and other civil servants. The cash income enables the non-poor category to access adequate

agricultural inputs such as hybrid seed and fertilizers. The non-poor category farmers have four or more cattle¹⁷ and own animal-drawn agricultural implements such as ox carts, ploughs, and seed-planters. Invariably, the non-poor group employs non-family labour on a permanent basis. In Shumba where horticulture was the main agricultural activity, all the non-poor had land near the river that was the main source of water for irrigating the vegetable gardens. Due to relative adequacy of farming inputs, the non-poor enjoy high crop yields. Farmers sell surplus crop or retain it to exchange for labour during the peak labour period in the next farming season. The non-poor category farmers easily qualified for the government supported agricultural inputs programme due to their impressive production records. In Maotsa, all the seven farmers that regularly received government sponsored fertilisers and seed for the winter wheat programme since 2004 were from the non-poor category.

Group 2 identified by Pankhurst (1988, 10) has access to the same level of off-farm income like the non-poor described above but the income was not invested in agricultural ventures. They employ labour on a temporary basis. This group was not identifiable during the period of study, as most of its members had migrated to urban areas, graduated into non-poor category or relegated to poor category.

Group 3 identified by Pankhurst (1988), this study terms the poor category. The poor category members receive no regular remittances, have no significant off-farm income and farming is the group's main source of livelihood. They lack cash to access adequate agricultural inputs especially hybrid seed and fertilisers. Since they own three or less cattle, they often have to rely on other farmers for draught power, entailing that most would occasionally be late in planting crops. The poor category farmers have low to medium yields and typically have little or no surplus to sell. They meet some of the clothing, food and cash deficits by selling labour to farmers in non-poor category. When

¹⁷ Interviews with community members revealed that owning more than four cattle classified one as non-vulnerable and therefore ineligible for welfare aid except in declared emergencies. Cattle are a source of milk, meat and importantly draught power and organic fertilizer (Davis and Dopcke 1987, 67). With the ever-rising rate of inflation and consequent erosion of the Zimbabwe dollar value, cattle increasingly became a dependable store of savings and a means of exchange.

the poor category members exchange labour during peak farming period they are unable to work adequately on their own plots, thereby further lowering their crop yields.

The last group identified by Pankhurst is termed the very poor category. They are mostly female headed or headed by senior citizens who often have to fend for orphans. They lack remittances and have no significant off-farm income, beside *ad hoc* donations. They typically own no cattle or farm implements. Children from the households are often either too young to work or would be attending school. The senior citizens are too old to work on land and can only perform light duties. Members of the very poor category receive aid from international aid organisations but cannot benefit from production-based interventions as they lack the necessary labour. The very poor category members have to purchase most of their food requirements because they do not grow enough to subsist.

The classification of rural farmers adopted here is similar to the one employed by the Government of Zimbabwe in its Poverty Assessment Study Survey II (GoZ 2006, 16). PASS II identified three categories of households in rural areas: the non-poor; the poor; and the very poor. The very poor households and individuals were those whose per capita monthly income expenditure was below the Food Poverty Line (FPL)¹⁸. The poor households and persons have monthly expenditure equal to or above the FPL but below the Total Consumption Poverty Line (TCPL)¹⁹. The non-poor households had monthly expenditure above the TCPL.

4.6 Conclusion

Some types of goods are non-excludable and non-rival in nature and hence will be produced sub optimally by the private sector. The public sector then has to provide these public goods. In Zimbabwe, the state has played a critical role in the delivery of public goods such as health and education services.

¹⁸ Food Poverty Line relates to the minimum amount required by a person in a year to buy a basket of food.

¹⁹ Over and above food, Total Consumption Poverty Line includes the minimum amount of the non-food items like clothing, education, health and transport required by a person in a year.

The decolonisation process had created states that were not able to exercise control over their hinterland. They were not able to provide the majority of their citizens with the necessary public goods, including education and health. There is consensus in the literature that the nation state model failed to establish in Africa due to poor leadership, unresponsive policies and external interference during the cold war (Trefon 2004, 3).

Recent scholarship indicates that the responses to the decline in service delivery have been differential. The international community responded by providing aid and funding NGO humanitarian operations. The local people also responded in varied ways. Some attempt to revive the state whilst others invest in service delivery mechanisms outside the framework of the state. Some migrate to developed countries from where they continue to send remittances. Others resort to voice strategies including protests but the majority try to provide the services at the local level. Communities create solidarity networks to compensate for the missing public goods. As noted by Trefon (2004, 18) in the DRC people compensated for the failures of the state by inventing, “a constellation of codes, discourses, systems and practices that permit the community as a whole to ward off the long-predicted apocalypse”. A substantial number fail to generate effective strategies, adapt, and learn to do with less or no education and health care.

Literature indicates that Zimbabweans have long-standing strategies of responding to adversities among them: leaving the country, temporarily or permanently, voicing, relying on private sector and NGOs, and creating solidarity networks to compensate for the failure of the state to provide the public goods.

CHAPTER FIVE: CONTEXTUALISING THE POLITICAL DEVELOPMENTS AND ECONOMIC DECLINE IN ZIMBABWE

5.1 Introduction

This Chapter provides a brief historical overview of the political developments and consequent economic decline in Zimbabwe that gave rise to state inability to deliver key public services. Though based on macro economic data, the purpose of this chapter is not to generate extrapolations for the micro cases used in this study or vice versa for that would constitute a logical fallacy. The aim however, is to contextualise the case studies; highlighting the macro political and socio-economic factors influencing the micro cases. As argued by Babbie, Mouton, Vorster and Prozesky (2005, 282) an ecology is critical in conceptualising, “the contexts in which the unity of analysis is embedded”. This Chapter establishes the nature of state capacity before failure and the levels of educational and health services accessed before the economic implosion. It is pertinent to review how the political and economic forces influenced state capabilities to deliver public services. Equally important is the need to establish whether the state was ever capable of adequate service provision.

The historical background is important, as there were continuities in ‘state consolidation’ in Africa from pre-colonial to postcolonial era. Despite European colonial rule in Africa characterised by violence and introduction of new economic systems, languages and religions, “it was impossible for the Europeans to have changed everything in the few decades they ruled Africa” (Herbst 2000, 4). In line with the argument by Herbst (2000), it was equally difficult for the post-colonial authorities to change everything upon gaining independence, thereby guaranteeing continuity from pre-colonial, via colonial to post-colonial state. Consequently, the present inextricably links to the past. In a recent study on Zimbabwe, Nhema (2002) notes such continuities from settler to post settler state. Between 2000 and 2007, numerous historical events contributed to the Zimbabwean state inability or unwillingness to deliver key public services. In this study, political and economic developments in Zimbabwe were divided into four chronological eras. Some of the eras have clearly discernible phases.

The first era covers the period of early European settlement and colonialism, between 1859 and 1979. The second era covers the first decade of independence from 1980 to 1989, the third era from 1990 to 1999, and the fourth phase from 2000 to 2007 (Sylvester 2003, 32; Sachikonye 2002, 16). The eras though shaped by major political and economic developments do not seamlessly dovetail but overlap. As argued by Sylvester (2003, 32), “although each period can be determined, there is overlap such that no one period offers unmistakable wholly dominant trend”. The economic stagnation in the late 1980s led to the adoption of the Economic Structural Adjustment Programme (ESAP) in the second decade of independence. The failure of ESAP to achieve the desired targets and its impact on the ordinary people led to the decline in popularity of the Zimbabwe African National Union-Patriotic Front (ZANU-PF). Against a backdrop of the declining popularity, the government from 2000 responded to demands from civil society organisations among others, the Zimbabwe National Liberation War Veterans Association (ZNLWVA) by implementing the populist land reform policies.

The first section of this chapter presents the geographic overview of Zimbabwe. The geographic overview is important as it has a direct bearing on the socioeconomic conditions of Zimbabweans. The majority of the population is still reliant on agriculture that in turn is dependent on soil quality and rainfall amounts and variability. The discussion on geography is followed by a brief overview of the colonial history of Zimbabwe. The aim is to establish the nature and character of education and health services provided during the colonial era and how the communities and individuals accessed these services. Later sections trace the socioeconomic and political developments in the three post-independence eras with special emphasis on how such factors influenced the provision of education and health services.

The first post independence era 1980-1989 was characterised by the expansion of social services including health and education. This decade also witnessed the co-option of the main opposition Zimbabwe African People’s Union-Patriotic Front (PF-ZAPU) by ZANU-PF, entrenching the political hegemony of the ruling ZANU-PF party. The

Marxian redistributive policies that the new government adopted in 1980 informed the rapid expansion of the public services (Sylvester 2003, 33). The immediate and rapid expansion of social services resulted in increased access to health and education facilities by the previously disadvantaged rural communities. However, the increased production of the public goods could not be funded by the decreasing state revenues leading to a gradual decline in quality of services and inability of the state to meet expenditure from government revenue.

The mismatch between revenue and expenditure led the government in 1990, to adopt an economic liberalisation programme that entailed structural adjustment of the economy. The economic reforms were implemented in two five-year phases from 1990 to 2000. The Breton Woods institutions (Sylvester 2003, 36) financed the first phase of the structural adjustment programme though initially proclaimed by government as 'homegrown'. The structural adjustment of the economy resulted in increased retrenchments, company closures, and the reduced access to health and education facilities following the introduction of user fees as a core element of the programmes. One of the significant political developments in the early 1990s was the formal discarding of the project to establish a *de jure* one party state by the ruling ZANU-PF party.

The third post-independence era that is the main period of focus of this study was an era characterized by the democratisation processes as evidenced by the decline of ZANU-PF majority in parliament because of the emergence of a formidable opposition political party. The transition to democracy paradoxically transpired at a time Zimbabwe witnessed an increase in political polarisation, a decline in the national economic performance, and an increase in the disregard for the rule of law. All were cataclysmic events contributing to state inability to meet its service delivery obligations.

5.2 Geography, Economy and People

Any discussion of Zimbabwe's political and economic prospects must take cognisance of the physical geography context as the rural economy is dominated by agriculture (CSO 1998, 7; Stoneman and Cliffe 1989 8). The political geography of a country also determines the ability of the state to broadcast its power and the nature of services it is able to extend to its population (Herbst 2000, 13).

Zimbabwe (formerly Southern Rhodesia, Rhodesia and Zimbabwe-Rhodesia) is a landlocked country in southern Africa in which African majority rule was achieved from Britain in 1980. Zimbabwe with a land area of 390,757 square kilometres shares borders with Botswana, Zambia, Mozambique and the Republic of South Africa (Kay 2006, 1297). The Zambezi and Limpopo rivers define its northern and southern borders. The population census of 2002 indicated a total population of Zimbabwe as 11,634,663 with an inter census growth rate between 1992 and 2002 of 1.1% (CSO 2002b).

Agricultural productivity in Zimbabwe is dependent on two main factors: rainfall patterns and soil quality.

Soils with good fertility and moisture retention characteristics are found in all regions but high proportions of better quality soils lie on the highveld, around the capital Harare and its surrounds. Despite the soil's agricultural potential variations, rainfall 'quality and variability' is the main factor in zoning agro-ecological regions in Zimbabwe (Stoneman and Cliffe 1989, 9).

The zoning divides Zimbabwe into five agro-ecological regions, from region I to V in order of rainfall quantity and reliability with region I receiving highest rainfall amounts and region V the least and most unreliable rainfall. Region I constituting less than two percent of the country land area receives high rainfall, more than 1000 mm annually (Stoneman and Cliffe 1989, 9). The region is favourable for specialised and diversified farming. The main agricultural activities include tea, coffee, fruit, forestry and intensive crop production (CSO 1998, 8). Region II covering fifteen percent of total area receives between 750 and 1000 mm of rainfall per year. The rainfall is reliable, well dispersed

during the rainy season making the region suitable for intensive farming, particularly the production of maize, tobacco, cotton and livestock breeding.

Region III receives between 650 to 800 mm of rainfall annually and 'intensity and variability are significantly greater' (Stoneman and Cliffe 1989, 10). Region III is suitable for semi-intensive livestock and crop farming with marginal production for maize, tobacco and cotton. The region covers nineteen percent of total area. Region IV receives 450-650 mm annually and is only suitable for extensive farming, mostly extensive livestock production and drought resistant crop varieties. In Region IV, "frequent mid-season dry spells make any form of dry land cropping risky" (Stoneman and Cliffe 1989, 10). Region IV constitutes thirty-eight percent of the total area. Region V consists of the Zambezi and Limpopo river basins and receives annual rainfall amounts of up to 450 mm. The rainfall is too low and erratic making the region unsuitable even for drought resistant crops (CSO 1998, 8). The region that comprises twenty-seven percent of area is suitable for extensive livestock production; game ranching and crops can only be grown under irrigation.

Zimbabwe is populated by the Shona constituting eighty-two per cent, Ndebele fourteen per cent, other African groups two per cent, Asian and Coloured, one per cent and White less than one per cent (CIA- The World Factbook 2007). The Ndebele are mostly confined to the western part of the country while the Shona populate the central and eastern part. Within the Shona linguistic group, exists several sub groups of the Karanga, the Korekore, the Manyika and the Zezuru. The exact numerical strength of the sub groups remains unconfirmed as the population census report does not disaggregate according to dialects. The subgroups were also the basis of regional patronages within the liberation movements and later in ZANU-PF government and lately in the opposition party, Movement for Democratic Change (MDC).

5.3 Brief Overview of Pre-independence Zimbabwe (1859-1979).

The occupation and history of Zimbabwe between 1859 and 1979 can be regarded as one era with several phases. The first phase was occupation of the country by missionaries on a civilising mission. The second phase was through formal colonial occupation and military conquest.

The first permanent settlement by Europeans in Zimbabwe was in 1859 with the founding of Inyati Mission by Robert Moffat (Zvobgo 1991, 2; Gann 1969, 44). Lobengula, the Ndebele King who ruled over most of present day Zimbabwe gave the missionaries full liberty to teach and hence they established the first formal educational institution for the indigenous population in Zimbabwe (Zvobgo 1991, 2). On 11 February 1888, Lobengula signed the Moffat Treaty in which he undertook not to enter into any agreement with a foreign power without previous sanction of Great Britain. The Moffat Treaty provided the basis for the Rudd Concession signed on 30 October 1888 in which Lobengula was to get firearms and a monthly pension. In exchange he was to give grantees, 'complete and exclusive charge over all metals and minerals contained in my kingdom, principalities and dominions' and that the European miners should have 'full power to do all things they may deem necessary to win and secure the same and to hold, collect and enjoy profits and revenues, if any, derivable from the said metals and minerals' (Gann 1969, 79). Based on the dispensation of the Rudd Concession, on 29 October 1889, Queen Victoria signed Letters Patent granting a Royal Charter establishing the British South African Company (BSAC). The royal charter gave the BSAC authority to operate in the then British Bechuanaland (now Botswana) to the west of Portuguese Territory (Mozambique) and beyond the Limpopo with no limit on the northern boundary assigned (Gann 1969, 82). On 12 September 1890, the Pioneer Column organised by Cecil John Rhodes of the BSAC to occupy Mashonaland established a settlement at Fort Salisbury (present day Harare) (Bowman 1973, 6; Gann 1969, 79).

Following a dispute over continued raids for cattle into Mashonaland by Matebele elements, in 1893, the BSAC invaded Matebeleland, which it defeated in the same year (Gann 1969, 117). Matebeleland was then added to Mashonaland and Manicaland to

form Southern Rhodesia. Both the Ndebeles and Shonas rebelled against BSA Company rule from 1896 to 1897 with the last resistance among the Shonas quashed in 1897. The Shona termed the violent confrontations *Chimurenga*²⁰ War of liberation and in later years this uprising became known as the First *Chimurenga*. Numerous factors caused the First *Chimurenga* but chief among them were the confiscation of Ndebele cattle by the BSAC after the 1893 rebellion; hardships experienced by both Shona and Ndebele because of the disruption of their traditional economy. Other grievances centred on the introduction of taxation and trade and the recruitment of forced labour for the newly established European mines and farms (Gann 1969, 82; Ranger 1968, 145; Zvobgo 1991, 38). The rebellious Shona and Ndebele were also concerned with recovering land alienated by the colonial settlers. Following the quashing of the rebellion, a legislative council was set up for Southern Rhodesia in 1899.

The Royal Charter had granted the BSAC rule for twenty-five years. Due to the First World War, Company rule was extended by another ten years. A referendum was held in 1922 to decide whether the territory should be given responsible government status under the British Crown or become a fifth province of the Union of South Africa. The referendum voted for a responsible government. In 1923, Southern Rhodesia became a self-governing colony under the British Crown with an independent Legislative Assembly. In 1931, the colonial government passed the Land Apportionment Act that divided the land in the country between Europeans and Africans.

The Roman Catholic Dominican Sisters arrived in Fort Salisbury on 17 July 1891 and established a hospital and a school immediately thereafter (Zvobgo 1991, 3). After gaining full control of the country, the BSAC donated land to missionaries on which they established their missions. The early missionaries pursued a three-pronged objective namely, preaching, healing and teaching (Zvobgo 1991, 85). The missionaries who

²⁰ *Chimurenga* a derivative from Murenga, meaning Murenga's wars to liberate the country from European colonisers in the 1890s. The first of Murenga liberation wars was 'precipitated, inspired and directed' by Murenga, the great high spirit of the Shona religion (Chigwedere 1991, 3). The 1966-1979 war of liberation in Zimbabwe drew inspiration from and was considered a continuation of the earlier *Chimurenga*, hence it became known as the Second *Chimurenga*. The dispossession of white owned farmland from 2000 was characterised as the third and final of the *Chimurengas*.

settled after the establishment of company rule generally catered for settler interests first before extending any support to the indigenous population, and “turning to the Shona only after they had established themselves as the preachers and nurses and teachers to the white community” (Ranger 1968, 141). By 1930, the colonial government had established only seven Venereal Diseases dispensaries in the African areas outside urban settlements and mines (Ncube 2009, 18). The government established its first rural clinic and hospital for Africans only after 1930.

On 11 November 1965, the Ian Smith led government undertook a Unilateral Declaration of Independence (UDI) for Rhodesia (Bowman 1973, 1). The UDI attracted international condemnation and isolation and the ‘independent’ Rhodesia failed to gain international recognition. The United Nations and the Commonwealth at the instigation of Great Britain, imposed sanctions on Rhodesia under which Rhodesia was to suffer until independence in 1980 (Bowman 1973, 2; Hill 2003, 60). The international boycott forced Rhodesia to industrialise and create an enclave economy to counter the sanctions. Within five years, “a massive programme of industrialisation had turned the country into the largest manufacturing base outside South Africa” (Hill 2003, 61).

The post World War II period witnessed the formation of broad based nationalist movements to fight the Rhodesian settlers. The African nationalist movements were to wage a protracted guerrilla war against the Rhodesian government from 1966, culminating in a negotiated settlement in 1979 (Hill 2003, 62). The main motivation for the war was to gain universal suffrage, erase racism and reverse the inequality inherent in the land distribution between the settlers and the indigenes (GTZ 1999, 23). The liberation struggle drew lessons, inspiration and meaning from the First *Chimurenga* and was characterised as the Second *Chimurenga*. The Second *Chimurenga* was the ultimate metaphor for voice by the colonised Africans.

In education, missionaries and local authorities provided a majority of schools yet they still relied on central government for grants especially teachers’ salaries (Nziramanga 1999, 2). The colonial government operated African schools in urban areas that were

better equipped and financed than the more expensive rural mission schools. The difference in cost caused many rural people to migrate to urban centres in search of better educational facilities, “this was one of the reasons for the flight of children from the reserves to urban areas” (O’Callaghan 1977, 24). Unlike urban schools, parents in rural areas always contributed to building and fees. The community raised substantial amounts to finance education. O’Callaghan (1977, 35) observes that, “voluntary labour is used to cut down building costs and registration fees are paid in addition to school fees”. The community boards established in African areas were “responsible for raising the money needed for expansion, but the poverty of the Africans, particularly in rural areas effectively limited that expansion” (O’Callaghan 1977, 26).

The education system inherited at independence was designed to cater for whites and only a few blacks. For the period up to 1980, the settler minority government provided superior education facilities for whites whilst relegating African education to charity work by missionaries (Narman, 2003, 141; Zvobgo 1986, 331; O’Callaghan 1977, 15). Stoneman and Cliffe (1989, 169) record that, amongst blacks, “only 42 per cent of children of primary school age were at school in 1979, and less than 20 per cent of the primary school-leavers were able to find secondary places, and even then only to be faced with high exclusion rates after two and four years”.

At independence, the government inherited a dual system of health with one highly modernized for whites and poor health services and infrastructure for blacks (GoZ 2004, 11). The doctor and hospital bed-patient ratio for the whites were high and comparable to those in the developed world whilst the statistics for blacks were typical for the third world (Herbst 1990a, 167). In 1980, the doctor patient ratio for whites was 1: 830 and 1:50 000-100 000 for blacks and there was one hospital bed for 219 whites and one bed for 525 blacks (Herbst 1990a, 167; Agere 1986, 358; Gilmurray, Riddel and Sanders 1979). Health facilities were concentrated in the urban areas, and

conversely there was little attention paid to preventive medicine which was allocated 8 per cent of the budget for the whole country; people in the distant rural areas generally received no primary health care; if they became seriously ill, they had to move to an urban area (Stoneman and Cliffe 1989, 173).

The majority of schools and clinics in rural areas were at independence non-functional due to war activities (Nziramasa 1999, 34). The education and health infrastructure had been destroyed during the prolonged war (Hodder-Williams 1983, 2). By 1979, the state had little control outside the European areas and could not offer any services in the 'liberated zones'. At the end of colonial rule, Zimbabwe managed to fund major investments in health and education achieving remarkable progress during the first decade.

5.4 A Decade of Expansion in Health and Education Services (1980-1989)

The end of a protracted liberation war resulted in general elections in 1980 based on universal suffrage. The year 1980 marked the end of colonial rule and establishment of majority rule with a government led by the indigenous people. The new constitution agreed at Lancaster House in 1979 had provisions reserving twenty seats for the white population ending in 1987 and a requirement that all land for resettlement could only be acquired on a 'willing seller, willing buyer' basis. ZANU-PF won 57 of the 80 seats available for Africans in 1980 and formed a government of national unity with the Zimbabwe African People's Union (ZAPU) that had garnered 20 seats. The unity government was short-lived as ZAPU ministers were dismissed on 18 February 1982 upon 'discovery of arms caches at properties owned by ZAPU' (Hill 2003, 76).

The ZANU-PF led government arrested ZAPU leaders and the fallout resulted in increased reports of 'dissident' (mostly deserters from the army) activities. The army was deployed to restore order under an operation code-named *Gukurahundi* that was to witness the death of between 10 000 and 30 000²¹ civilians from 1982 to 1987 (Sachikonye 2002, 16; Darbon 1992, 13). During the conflict in Matabeleland and the Midlands regions, the state was unable to ensure security and public order in the three provinces. The heavy-handedness of the army in an attempt to restore order even became a further source of insecurity for the majority of citizens accused of harbouring

²¹ The most authoritative published report on the *Gukurahundi* (the early spring rains that wash away the chaff) activities was the Catholic for Justice, Peace, and the Legal Resources Foundation (1997). Hodder-Williams (1983) detail the evolution of the conflict in Matabeleland and the rationale of government response.

‘dissidents’. The conflict in Matabeleland had long lasting consequences as regards loyalty of the rural electorate to ZANU-PF. A tendency to align political allegiance along ethnic lines evident in the 1980 elections developed becoming apparent in later elections (Hodder-Williams 1983, 130). In Ndebele speaking regions ZANU-PF was unpopular whilst in Shona speaking regions it was presented as a protector against domestic and foreign enemies including opposition parties. The pattern of political support based on ethnic contours was to continue into the twenty-first century.

The early years of independence were devoted to the reconstruction of war-ravaged economy and infrastructure as schools and health institutions reopened from 1980. The reconstruction of schools was decentralised as local authorities and communities through the newly established school development committees facilitated community participation in the construction and maintenance of infrastructure. The reconstruction programme ‘took off’ well as the first two years of independence, 1980-81 were boom years of economic performance buoyed by the end of war, renewed access to international aid, opportunities for external borrowings and favourable weather (Kanyenze 2003,42). However, “the boom was cut short by three consecutive years of drought, the worst since 1911-14, the onset of world recession, the decline in the terms of trade and the deteriorating internal security situation as insurgency mounted in Matabeleland and the Midlands” (Kanyenze 2003,44).

Since 1980, education received generous allocation from the national budget (Zvobgo 1986, 341). Government adopted four main complementary policies to promote access to education namely: the universal primary education implemented soon after independence; a 1987 legislative amendment that made primary education tuition free; on-the-job training for teachers; and decentralising responsibilities for managing schools to communities (GoZ 2004, 25).

The Education Act recognised education as a fundamental right, specifically that, “every child in Zimbabwe shall have the right to school education” (GOZ 1996a, 619). In that regard, free and compulsory education became one of the primary objectives of

government (Narman 2003, 143). Increased access resulted in the hike in school enrolments (Nziramasanga 1999, 9). From 2401 primary schools enrolling 81,958 learners in 1979, the number of schools rose to 4,504 enrolling over 2,274,178 learners by 1989. Equally, phenomenal increases were recorded in secondary education from 177 secondary schools enrolling 66,215 learners to 1,502 secondary schools with a learner population of 695,882 by 1989. University enrolments increased from 1941 in 1979 to over 7000 in 1989.

Significant budgetary allocations supported the increased enrolments. Central government provided a grant for salaries for all teachers in both government and non-government schools. The government also annually allocated a pupil unit based tuition and building grants. Tuition grants covered costs for teaching materials such as books, stationery whilst the building grant was for the erection of new and maintenance of infrastructure. Allocations of the grants were “based on the revenue available to government rather the actual cost of the pedagogic materials’ (Singleton 2006, 31).

The communities would contribute labour and other local inputs for infrastructure development (Chung 1988, 123). From independence in 1980, cost sharing in education in rural areas remained one of the principal instruments of financing the provision of primary and secondary education (Narman 2003, 148). By 1989, eighty percent of the education budget covered teachers’ salaries and came from government for both government and private schools (Stoneman and Cliffe 1989, 169).

As a direct result of the government initiated programmes, major indicators in education improved, literacy levels for 15-24 year age group rose to 98% by 1999 (GoZ 2004, 23). The first ten years of independence were marked by a ‘consumption national expenditure policy’ and the rapid expansion in the provision of public goods without the matching human, financial and infrastructural resource base (GTZ 1999, 26; Nziramasanga 1999, 10). Education acquired some characteristics of public goods when made free and compulsory soon after independence. Its provision acquired some jointness and it became difficult to exclude the free riders. The challenge was that being free also meant that

demand was high. Qualified teachers shunned the poorly resourced rural schools (Nziramasanga 1999, 12). The high demand for education resulted in many pupils failing to access adequate learning material and infrastructure, “pupils often met with buildings that were far from ready, or constructed for temporary use, or even classes that were held in the open under tree” (Narman 2003, 145). The government met the increased demand for teachers by recruiting temporary unqualified and in rural areas under-qualified teachers (Chung 1988, 125). The inadequate resources and massive recruitment of unqualified teachers resulted in very low pass rates at ordinary level throughout the 1980s (Narman 2003, 146). Despite achieving quantitative growth, the output quality was on a decline and creating a dichotomy of well-resourced urban and private elite schools offering elitist education versus the poor rural schools producing poor results (Nziramasanga 1999, 12). The health sector recorded similar phenomenal gains soon after independence.

In the early years of independence, government adopted a policy meant to achieve health for all by 2000. Access to health became a fundamental right (Agere 1986, 369). The major components of the policy entailed emphasis on primary health care, establishment of rural health centres, free treatment of the under fives and pregnant women in public institutions and the expanded programme on immunisation against childhood infections, introduction of a multipurpose village health worker, and contraceptive practice programmes (Loewenson and Sanders, 1988, 140-1). The village health workers recruited from the respective communities were pivotal to the delivery of primary health care as they were “trained in basic preventive, promotive, curative and rehabilitative interventions targeted mostly at the rural areas” (Agere 1986, 372). Government deliberately gave more attention to needs of rural population and shifted resources from curative to preventive services. The cost of curative care increased from Z\$74 906 000 in 1980-81 to Z\$ 107 290 000 in 1982-83 whilst allocations for preventive care rose sharply from Z\$5 598 000 to Z\$17 337 546 for the same period (Agere 1986, 364).

Central government provided fiscal transfers to local authorities to reimburse them for the costs incurred in providing subsidized health facilities to the poorer sections of the community. The Ministry of Health and Child Welfare also met salary costs for all medical staff in the public sector. Immunisation of children against the major killer diseases was since 1982 expanded, made free and compulsory under the Zimbabwe Expanded Programme on Immunisation (ZEPI) (GoZ 2004, 11; PRF 2003, 19)²².

At least 163 new health centres were built and 450 existing primary care clinics upgraded countrywide (Agere 1986, 364). The number of health centres increased significantly from an average of 9.5 per 100 000 in 1980 to 15 per 100 000 in 1985 (Dashwood 1996, 36). Through the institution of village health workers, basic hygiene improved as 40 212 ventilated improved pit (VIP) 'Blair' toilets were constructed and 10 370 protected wells constructed throughout the country by 1984 (Agere 1986, 372). The new policy on free health care for all those earning Z\$150 or less introduced in 1980 increased accessibility to health facilities (Dashwood 1996, 36). Because of these policies, major health indicators improved greatly in the eighties but started to deteriorate in the late 1990s (GoZ 2004, 11).

Early signs of economic stress could be detected in late 1982 when the country had its first balance of support from the World Bank. The loan had several conditions including: the devaluation of the Zimbabwe dollar by 20% on 9 December 1982; the introduction of export incentives; liberalisation of the foreign currency allocation regime; restrictions on new non-concessionary foreign borrowings from 23 March 1983; restriction on government credit expansion; restriction on recruitment; and general reduction in government spending (Kanyenze 2003, 46; Logan and Tevera, 2001, 108). Dashwood (1996, 27) argues that the conditions entailed that government effectively cut on social expenditure. External debt rose from US\$786 million in 1980 to US\$2304 million by 1983, debt service ratio rose from 1.3% of export earnings in 1979 to 25% by 1983, "generating additional pressure on the balance of payment" (Kanyenze 2003, 45). The

²² The child killer diseases include measles, tetanus, polio, typhoid, tuberculosis, diphtheria, hepatitis B and haemophilus influenza.

continued military involvement of the Zimbabwean army in the Mozambican civil war put further pressure on the economy (Kanyenze 2003, 46).

During the first decade of independence, the ZANU-PF government missed opportunities for developments due to divisions and rivalries and regional patronages within the party. ZANU-PF was from the beginning and continues to be non-monolithic organisation (Hodder-Williams 1983, 5). Since its formation the ZANU-PF party has attracted ‘diverse and heteroclit groups assembled around different leaders and political tendencies’ (Darbon 1992, 12). Since its formation in 1963, ZANU-PF has had factions around major ethnic groupings in the country: the Karanga, the Korekore, the Manyika and the Zezuru. The regional patronages constrained ZANU-PF from disciplining renegades including those found guilty of corruption²³ and misappropriation of funds. The party was constrained when implementing tough decisions as “each and every faction had the power to prevent a decision; none has seemed strong enough to impose one” (Darbon 1992, 17).

Despite impressive growth rates in the 1980s, the social indicators began to deteriorate significantly in the late 1990s (GoZ 2004). By 1989, economic development had effectively stagnated, forcing government to implement reluctantly, an Economic Structural Adjustment Programme (ESAP) (Narman 2003, xv).

5.5 A Decade of Liberalisation (1990-1999)

The 1990s in Africa witnessed a ‘wave of political liberalisation’ and the opening up to multi-partyism (Herbst and Mills 2003, 12). The 1990 decade in Zimbabwe was distinguishable by the formal withdrawal by ZANU-PF of its proposal to establish a *de jure* one party state. In 1990 President Mugabe announced that he would not call for a referendum on the issue of establishing a *de jure* one party state, ‘since the existence, *de facto*, of such a party should be sufficient for the needs of the country’ (Quantin 1992, 42). The attainment of *de facto* one party state had far-reaching consequences on loyalty.

²³ The Justice Smith Commission set up in 1985 to investigate the operations of parastatals, the Justice Sandura Commission set up in 1988 to investigate allocation and distribution of vehicles under a government-sanctioned scheme revealed cases of corruption by senior government officials (Darbon 1992, 19).

The one party dominance enabled ZANU-PF government to make judicious appointments of key civil servants especially at sub national levels (Hodder-Williams 1983, 7). Such civil servants in charge of electoral processes at local levels were crucial in ensuring rural electorate support for ZANU-PF as it became an unwritten requirement to assist ZANU-PF if they needed to maintain their posts.

In 1997, civil society groupings comprising students, churches, academics and labour coalesced to form a National Constitutional Assembly (NCA) to campaign for constitutional reforms (Nhema 2002, 142). The government responded to the formation of the NCA by appointing a 400 member Constitutional Commission to consult and come up with a draft constitution for submission before a referendum. In 1999, a new political party, the Movement for Democratic Change was born out of the NCA, the student and labour movements (Hill 2003, 105).

On the economic front, the 1990s witnessed the adoption of ESAP and the abandoning of socialist informed development policies. The 1990s was a decade of “rolling back the frontiers of the state” which entailed a reduction in the government’s role in the provision of social services and the increasing role assumed by the private enterprise. In 1991, the Government of Zimbabwe adopted ESAP funded by the World Bank and International Monetary Fund (IMF) and implemented from 1991-95 (Sachikonye 2002, 14; Logan and Tevera 2001, 100). ESAP entailed *inter-alia*: the deregulation of economy, the deregulation of prices and wages, the reduction in public spending, reduction in central government deficit, the introduction of cost recovery on health and education (CSO 1998, 2) and the greater role of the private sector in the market and ‘the state was to intervene far less directly on behalf of the poor’ (Dashwood 1996, 27). The key targets of ESAP were to: increase Gross Domestic Product (GDP) growth rate to 5% during 1991-95, raise savings and investment to 25% of GDP, increase export growth to 9% per annum, reduce budget deficit from over 10% to 5% by 1995, and reduce the inflation rate from 17,7% to 10% by 1995 (Kanyenze 2003, 56).

ESAP attained its goal of liberalising the economy and the removal of foreign trade restrictions and foreign exchange restrictions. However, it failed to attain other targets and real Gross Domestic Product (GDP) growth between 1991 and 1995 averaged 1,5% per year and employment creation at 0.8% (GOZ 2004, 11; Kanyenze 2003, 62). Poverty levels increased dramatically from 1990 to 1995. The Poverty Assessment Survey Study (PASS) I undertaken in 1995 by the government of Zimbabwe recorded that extreme poverty rose from 26% of households in 1990 to 45% in 1995 falling below the Food Datum Line (FDL) (GoZ 1997). The same study established that the Total Consumption Poverty Line had risen to 61% for all households.

Gains made in the social sectors during the first decade of independence began to reverse during the era of economic reform. The reduction of government expenditure during ESAP undermined the health delivery system (Chisvo 2000, 23). The “negative effects of ESAP were both immediate and sustained” (Hammar *et al* 2003, 6). The state gradually introduced cost recovery in the health and education sectors with dire consequences for the poor, as the result was that there was decreased utilisation of these public goods (Kaseke 1998, 251).

With the deteriorating macro environment, the state failed to meet the needs for the provision of health care. The health indicators declined dramatically: between 1985 and 1999, infant mortality increased from 40 to 65 per 1000 live births and under-five mortality increased from 59 to 102 per 1000 (GoZ 2004, 35). Maternity deaths also rose from about 283 per 100 000 live births in 1984-1994 to about 685 per 100 000 live births by 1999 (GoZ 2004, 41). Increased poverty and HIV infections caused a resurgence in Tuberculosis (TB) cases that increased from 9132 cases in 1990 to 30831 cases in 1995 reaching 51918 cases by 2000 (PRF 2003,16).

Despite the new government’s avowed commitment to redress the divide in public service delivery between the rural and urban, the post-independence fiscal allocations continued to favour the urban residents. Changes in allocations under ESAP were to adversely affect the rural more than the urban population as the post independence

investment had favoured the richer urban. Commenting on the meagre support to village health workers, Agere (1986, 372) argues, “this view questions the seriousness of the programme, considering that urban wage earners receive better health services which are fully staffed, with qualified personnel on full time basis covering a quarter of the whole population”. The contradictions in government allocations were not only confined to health but were also evident in other social sectors particularly education. To cushion the vulnerable groups against the negative impact of the structural adjustment programme, government introduced a Social Development Fund. The Fund provided for an employment and training programme, targeting food subsidies, and the provision of exemption from cost recovery measures for the vulnerable (Kanyenze 2003, 65).

In the education sector, some indicators began to deteriorate in the 1990s after the introduction of ESAP. Cost recovery under ESAP reintroduced school fees that led to an increase in dropouts and a decline in completion rates of primary education (GoZ 2004, 23; Narman 2003, 149; Chisvo 2000, 23; Kaseke 1998, 251). ESAP resulted in cuts in public expenditure for education by central government from 1990 and a gradual shift to more spending on education by the citizens. From 1990 to 1998, the spending by parents and guardians on education increased fivefold (GTZ 1999, 17). Given the increasing levels of poverty as recorded by PASS I (GoZ 1997), the “dwindling public educational resources are confronted by the diminishing ability of families to take advantage of what is on offer” (GTZ 1999, 17).

Enrolments continued to increase during the second decade of independence. By 1997, enrolments in primary schools reached 2.5 million learners in 4,670 schools and in secondary schools, there were over 800,000 learners in 1,530 school and teacher training college enrolled over 19,000 students in fifteen colleges, an increase from 2,829 students in eight colleges in 1980 (Nziramasanaga 1999, 35). However, infrastructure was still inadequate at poorly resourced rural schools ‘where in many schools classes were still held under a tree’ (Nziramasanaga 1999, 46).

A follow up programme to ESAP, the 'home-grown', Zimbabwe Programme for Economic and Social Transformation (ZIMPREST) 1996-2000 failed to attract external support and was only launched in April 1998 (PRF 2003, 10). Lacking adequate funding, ZIMPREST was a failure and could not attain its objectives that were similar to ESAP.

Poverty and hunger, with higher prevalence in rural and disadvantaged communities, led to low enrolments and erratic school attendance and school dropouts with, 'the HIV and AIDS pandemic seriously undermining the education system, indiscriminately affecting pupils, their parents and teachers' during the second decade of independence (GoZ 2004, 24). The deterioration of the quality of services provided by government got impetus from the decline in the general economy.

There was a further down turn of the economy beginning in 1997, arguably triggered by a decision to grant veterans of the 1970s nationalist liberation movements, pensions and gratuities from unbudgeted funds²⁴ (Rotberg 2007,169; Hammar et al 2003, 7; Logan and Tevera 2001, 113). Equally damaging to the ailing economy was the deployment of Zimbabwean troops in the Democratic Republic of Congo in 1998 at a cost of US\$360 million annually (Moore 2005b, x; Sachikonye 2002, 14). In 1997, the government set up a war victim fund to compensate victims of the liberation war. The fund was grossly abused by the party and government officials with about Z\$240 million (then US\$40 million) reported missing (Hill 2003, 94).

The balance of payments deteriorated from a favourable balance of US\$210 million in 1995 to a deficit of US\$596 million in 2000 and as a result, the country failed to meet its external debt obligations for the first time in May 1999 (Kanyenze 2003, 31). Recurring droughts and occasional floods made the impact of the crisis more severe (GoZ 2004, 11; Narman 2003, 31; Singleton 2006, 7).

²⁴ In December 1997 each of the over 50 000 war veterans received a gratuity of Z\$50 000 (about US\$4500 then) and a monthly pension of Z\$200 thereafter beginning in January 1998 (Muzondidya 2009; Kanyenze 2003, 68).

Against the general decline in services, the quality of teaching personnel improved during the second decade of independence. In 1990, only 51, 5% of the 60 886 primary school teachers were trained, yet by 2000, the percentage of trained teachers had increased to 88,4% out of a total of 66 640 primary school teachers (GoZ 2004, 23).

The ESAP reforms though necessary for the recovery of the national economy failed to achieve the desired targets due to “poor governance” of the implementing states (Herbst and Mills 2003, 12). The major achievements realised from 1980 to 1989 quickly eroded during the era of structural adjustment (Kanyenze 2003, 68).

5.6 An Era of Transition to Democracy, Economic Decline and State Service Delivery Failure (2000-2007)

The decline in Zimbabwe state’s ability to deliver public services was a dynamic and gradual process occurring over several years. Political and economic factors define specific phases from 2000 to 2007. There are three discernable and linked phases in the 2000 to 2007 era. However, though there are distinguishing features for each phase, the 2000 to 2007 era is marked by common feature of accelerated economic and political decline in Zimbabwe.

2000-2003 Years of Reaping Independence Dividend

The year 2000 was a watershed in several political and economic respects. Politically, the year marked the end of hegemony of ZANU-PF and the introduction of a formidable opposition in Zimbabwean politics (Raftopoulos 2009, 204). On 14 February 2000, the government put the draft Constitution to a referendum and lost to the MDC that had campaigned for a NO vote. It was the first time ZANU-PF had lost any vote since 1980 and it was only a harbinger of more NOs to come in elections from 2000. In direct response to the loss of the referendum and the prospect of losing the general elections scheduled in a few months time, the ZANU-PF government sponsored the takeover of white-owned farms under an operation spearheaded by elements of veterans of the liberation wars (Raftopoulos 2009, 211; Brown 2006, 1300; Bratton *et al* 2005, 79; Moore 2005b, x; Kriger 2003, 195).

The ZANU-PF government presented this period as marking the beginning of the Third *Chimurenga* (liberation war) meant to remove the last vestiges of the colonial rule. The Third *Chimurenga* was ostensibly, “the third and final installment of the liberation struggles first mounted in the 1890s” (Primorac and Muponde 2005, xiii). It involved the often violent takeover of white-owned farms in the name of redressing colonial injustices. According to Mamdani (2008), the land reform was necessary to remove the last vestiges of colonial rule and that Zimbabweans will remember the period 2000-3 as years independence was achieved; years marking the end of colonial rule. Bratton *et al* (2005, 87) argue that a majority of Zimbabweans were in favour of land reform but preferred it to be “accomplished by legal, peaceful and economically sound means”. The farm occupations involved opportunistic accumulation as the new settlers harvested pre-planted crops and stripped farms of assets from ranch fencing to boreholes.

The central government was also to award an unbudgeted for 69-100% increase in civil service salaries in January 2000, just a few months before the Parliamentary elections (Kanyenze 2003, 68). The economic decline also received an impetus from farm invasions that triggered breakdown of rule of law since 2000 (Bratton *et al* 2005, 79; Narman 2003, xvi). An eighteen month stabilisation programme, the Millennium Economic Recovery Programme (MERP) implemented from beginning of 2000 became another spectacular failure as all international support save for humanitarian aid had been withdrawn (Sachikonye 2002, 14). Real GDP growth rate reached -14,5% per annum in 2002 (PRF 2003, 11). Local borrowing by government funded the public sector. Some basic services were still provided as government continued to borrow from the local market and printed money to fund the essential projects such as school examinations and importation of essential medical drugs. A study on public opinions of ordinary Zimbabweans in 2004 revealed that 54% considered their living conditions to be bad (Bratton *et al* 2005, 83).

The health indicators deteriorated further. Under nourishment for children, under-five year olds was also on the increase, rising from 13% in 1999 to 20% in 2002 with malnutrition accounting for 34% of child deaths (GoZ 2004, 36). Life expectancy at birth fell steadily from 61 years in 1990, 55 years in 1995, 43 years in 2000 and 36 years in 2004, with 37 years for males and 34 years for females in 2007 (GOZ 2004,12). The interplay between deteriorating economic fortunes and the onset of the HIV and AIDS pandemic jointly conspired against and severely challenged the health delivery system (Sachikonye 2002, 15). However, HIV prevalence in pregnant mothers declined from 26% to 18% in 2006 (UNAIDS 2008).

With unemployment rates of over 80%, health insurance only covered the small portion of the population in formal employment, leaving out the poor, the aged and those suffering from chronic conditions to rely on family resources or external donor support. Health insurance and private medical practice were also limited to urban centres. Due to sparse geographical population distributions and high incidence of poverty outside urban areas, provision of private health care was unviable or its costs unaffordable in rural areas.

In the education sector, reduced government funding resulted in an increase in pupils per teacher ratios and a simultaneous decrease in teachers' salary levels leading to resignations by some teachers. From about 2000, there was an exodus of qualified personnel in the education sector. Morale among education professionals was low due to increased workloads and worsening working conditions (GoZ 2004, 24). Schools lacked basic teaching and learning materials and both students and teachers were required to buy their own textbooks and stationery (Chimhete 2007).

The Basic Education Assistance Module (BEAM) introduced by government in late 1990s as a component of the Social Development Fund to support children from disadvantaged backgrounds increasingly had reduced impact. BEAM's main objective was to reduce the number of vulnerable children dropping out or not attending school due to economic hardships by providing school fees waivers in secondary and primary

schools. There were more applicants due to the deteriorating economic situation. BEAM allocations declined in real terms and were eroded by inflation by the time it got to the beneficiary²⁵.

Despite the education and health sectors receiving very high proportions of government expenditure, from 2000 the allocations have been decreasing in real terms due to the inflationary conditions. By 2003, though there was a higher proportion of overall government expenditure directed towards the social services, especially health and education most of the funds were spent on overheads mostly wages and salaries. Ninety-five percent of the education budget went to salaries and in health, 96% was spent on staff costs with only 4% on drugs and medical supplies (Singleton 2006, 14). During this period Zimbabwe, one of the African states, “previously considered to be among the most solid and prosperous” was beginning to fail (Herbst and Mills 2003, 8).

2004-2006 Accelerated decline

There was a further deterioration in the Zimbabwean economy between 2004 and 2006. The Reserve Bank of Zimbabwe financed the public sector by printing money during this period. There was also extensive borrowing from the local market to finance the land reform programme and other ‘emergencies’. The borrowings by the Central Bank were without sanction of Parliament as is required by the Zimbabwean Constitution.

The state also became openly predatory as it failed to honour payments for gold deliveries and appropriated proceeds from the sale of tobacco, the major foreign currency-earning crop. In 2005, the government promulgated a constitutional amendment that disallowed appeal against compulsory acquisition of land (Tatic and Walker 2006, 666).

²⁵ Interview with Mrs. Mutowo, Programme Officer in Department of Social Welfare held on 19 May 2008 at Harare.

In 2005, the IMF threatened Zimbabwe with expulsion for non-payment of arrears and a late payment in September that year prevented expulsion (Tatic and Walker 2006, 666). The economic decline continued till 2007 when the economy was characterised by a currency shortages (both local and foreign) on the official market, a thriving black market for foreign currency, declining export value, increasing government domestic debt, and increasing arrears on external debt. Other challenges recorded include: uncontrolled price increases, severe shortages of goods on the official and parallel markets, hyperinflation, and general lack of confidence in the official market system.

Public spending priorities changed as focus shifted from the rural areas to the newly resettled farmer economy. As the inflation rates increased, school fees and the prices for local goods also increased because they were linked to a rapidly appreciating United States (US) dollar. The economy was beginning to dollarise. As a response to the increasing inflation levels, the central bank in August 2006 devalued the Zimbabwean dollar and removed three zeros from the currency (Europa 2008, 5021).

2007 Hyperinflation and State Failure

The Zimbabwean economy officially hyper-inflated at the beginning of 2007 when in March 2007, inflation officially rose to 50,5%²⁶ on a month on month basis closing the year at 240,1%. Table 2.1 shows sharp rises in both Consumer Price Index (CPI) and rate of annual inflation between 2000 and 2007. The All Items CPI increased 26 751 fold from 469,6 per year in 2000 to 12 562 581,7 by end of 2007.

Table 5.1 Zimbabwe Inflation Rates 2000-2007 (2000=100)

Year	All items Consumer Price Index (CPI)	Year on Year Price (Inflation) Increases (%)
2000	469.6	55.9
2001	100.0	71.9
2002	233.2	133.2
2003	1 084.5	365.0
2004	4 880.3	350.0
2005	16 486.4	237.8
2006	184 101.1	1 016.7
2007	12 562 581.7	6 723.7

Source: RBZ. <http://www.rbz.co.zw/about/inflation.asp>. Retrieved on 19 September 2008.

²⁶ Hyperinflation, defined as when the rate of inflation reaches 50 percent or more per month. It is a rare occurrence there having been only 29 other cases in history with Zimbabwe being the first country to experience hyperinflation in the twenty-first century (Hanke 2008).

Save for brief interruptions in 2004 and 2005, official inflation was constantly on the rise on an annual basis since 2000 reaching a peak of 6723,7 per cent for 2007. Independent estimates put the annual inflation rate for 2007 much higher at 215 000 percent per annum (Hanke 2009).

There was a collapse of the national currency in 2007 leading to cash shortages of both local and foreign currency making normal trading onerous. The crash of the local currency led to the collapse of the official support for the health and education sectors. There was compromised service delivery due to perennial job stay-away by the civil servants.

Fuel and agricultural inputs shortages hindered both agricultural and industrial production. Industries operated at below 20% capacity resulting in shortages of basic commodities such as foodstuffs, medicines, soap, cooking oil, sugar, stationery and medicines. The economy also experienced serious shortages of fuel and electricity and brain drain. The continued decline of Gross Domestic Product (GDP), spurred inflation and limited savings and investments (RBZ 2008b, 21). Agricultural production had declined over the previous eight years and in 2007, the country faced a major cereal deficit²⁷ for the second year running (RBZ 2008b, 21). Zimbabwe had effectively moved from a net food exporter to a net importer of staple food.

The quality of health services rendered deteriorated with the mass exodus of health personnel leaving the public sector or country altogether. Some health centres particularly in the rural areas had closed down as all trained personnel had left the service (The Standard 2007, May 6). In all public health centres, equipment invariably broke down due to the lack of maintenance and there was a chronic shortage of drugs. The salaries were so low that health personnel absconded from duty as they failed to raise money for transport to and from work (Shoko 2007).

²⁷ Zimbabwe had an estimated net deficit of about 1200 metric tonnes for maize for 2007-8. Production of the main foreign currency earner, tobacco declined from 232 million kg in 2000 to about 55 million in 2006 marketing season (Mafunda 2007).

Primary health care had effectively collapsed. Commenting on the state of health facilities, the Minister of Health and Child Welfare admitted, “I am also aware that there is a serious shortage of human and material resources in the country to effectively deliver quality midwifery care” (The Herald 2008, July 26). Though the nominal national budget allocations for health has remained high, for five years since 2003 there has been challenges in implementing the budgets in an inflationary environment (Singleton 2006, 7). In education, there was an exodus of qualified teachers. Schools lacked basic pedagogic materials and boarding schools faced serious food shortages.

In terms of international relations, though Zimbabwe still enjoyed considerable support from Africa and particularly Southern African Development Community (SADC) it had acquired the status of a pariah state within the European Union and the United States²⁸. It was estimated that about a quarter of the twelve million Zimbabwean population had left the country for mostly South Africa and the United Kingdom (Tarisayi 2009, 12; Brett c2004).

However, it is important to note that as the contraction of public services in the country occurred there was also simultaneously experienced some degree of democratisation. In 2000, the new opposition MDC garnered 56 of the 120 of the elected Members of Parliament. The number of opposition seats declined to 41 and one independent in 2005, increasing to over 110 for MDC and 99 for ZANU-PF out of 210 after the 29 March 2008 harmonized elections (Europa 2008, 5014).

5.7 Conclusion

The Chapter outlined the background context to the study. Zimbabwe, a former British colony, at independence in 1980 inherited racially biased health and education systems. The new government adopted socialist informed policies to correct the racial imbalances

²⁸ Zimbabwe has since 2000 been suspended from the World Bank and could not leverage IMF funds. The United States and the European Union have from 2002 reduced aid and imposed targeted sanctions specifically an embargo on arms sale, travel ban and asset freeze for high-ranking government officials. This is because that EU and US accused Government of Zimbabwe of human rights abuses and rigging elections.

in access to health and education. The welfarist policies resulted in sudden and phenomenal improvements in health and education indicators during the first decade of independence. School enrolments increased with the introduction of free and compulsory education. Access to primary health care became near universal as new facilities were commissioned on the backdrop of a new policy exempting payment for health services for all citizens earning Z\$150 per month or less. The expenditure to meet the commitments on social services during first decade of independence was too high to be sustainable in the long term. The economy stagnated towards the end of the 1980s prompting government to implement structural adjustment programmes.

The World Bank and International Monetary Fund sponsored economic structural adjustment programmes that commenced in 1991 failed to meet set targets. ESAP also led to changes of policies in funding and delivery of social services. Government introduced cost recovery in education and health services leading to reduced access and consequent decline in major indicators in health and education services around the mid 1990s. The period 1990-1999 when Zimbabwe liberalised the economy witnessed reversal of gains achieved during the first decade of independence.

From 2000, the Zimbabwean economy has been on freefall leading to hyperinflation. The free-fall of the Zimbabwe economy since the turn of twenty-first century, because of a cocktail of domestic policy misadventures and international isolation gradually led to the collapse of the health and education service delivery capacity by 2007.

Post-independence policies, corruption and misappropriation of state resources, military adventurism in Mozambique and Democratic Republic of Congo and occasional natural calamities precipitated the decline in Zimbabwe's fortunes. The Zimbabwe state was "hollowed out" and failed to deliver education and health services. The rise of a formidable opposition political party in the form of the MDC and other broad based civil society organisations such as the NCA around the turn of twenty-first century could not stop the country from plunging into lawlessness. By 2007, schools and clinics were barely functional, lacking essential equipment, human and operational resources.

The state decline and eventual failure to deliver key public services in Zimbabwe was therefore not sudden and unexpected. The danger warning signs existed for a long period and both the local actors and the international community (Hill 2003, ix) took no corrective action.

University Of Cape Town

CHAPTER SIX: MAOTSA, EDUCATION AND HEALTH FINDINGS

6.0 Introduction

This chapter discusses findings on how Maotsa community and individuals responded to the decline in education and health services. The Chapter is divided into three main sections. The first section covers findings on education whilst the second one concentrates on health issues. The third section covers the crosscutting issues that overarch health and education. Responses to the decline in education and health services were grouped into conceptually distinct but related strategic responses namely: gradual change from reliance on state to avoidance of the state, local direct action, leveraging external support, voice, exit, teacher-based actions, perverse coping, reordering of the health services, apathy and helplessness. Particular attention is given to how the diverse interests and segments of communities were affected and their specific responses to the failure by the state to provide education and health services. The different categories of the community, mainly teachers, health personnel, parents, local governments and faith based organisations as responsible authorities for schools and clinics were impacted differently by the decline in public services. In turn, a variety of responses to the decline of education and health services emerged from different segments of the community.

This Chapter further establishes the chronology of the coping strategies deployed by the different segments of the community. The chronological events are closely aligned to the phases between 2000 and 2007 identified in chapter five. The first phase, 2000 to 2003 were years of reaping the independence dividend, 2004 to 2006 were years the country underwent dramatic declines in service provision. The final phase beginning 2007 was characterised by hyperinflation leading to eventual inability by the state to meet its basic obligations in public service delivery. This chapter also analyses the effectiveness and sustainability of the coping strategy adopted.

6.1 Education

In Maotsa, there are three primary schools: Kanongovere, Mukwasi, and Mushipe and two secondary schools: Kanongovere and Serima. Serima secondary school was a Roman Catholic boarding school established during the colonial era. It charged high fees and only the elite such as businesspersons and civil servants could afford the fees. Learners at the boarding school were drawn from throughout the country with at least half of the learners from Harare, the capital city. Kanongovere secondary school, administered by the local council, was one of the rural day secondary schools established with assistance from the new government in 1980. The three primary schools were established in the colonial era and were all administered by the local Rural District Council. The state of education facilities and services offered by these institutions were on a general decline from 2000, due to the deteriorating macroeconomic conditions particularly the high rates of inflation and reduced contributions from the central government.

6.1.1 From State Reliance to State Avoidance

The study identified major changes and reactions from an initial reliance on state grants by schools in 2000 to a situation where school authorities actively avoided state grants as a survival strategy. In the terminology of Azarya and Chazan (1998), it was a movement from full engagement to disengagement. The strategy was a form of internal public exit.

In response to the adverse effects of the Economic Structural Adjustment Programme (ESAP), the government in 2001 introduced the Basic Education Assistance Module (BEAM) as part of a broad based social protection scheme (UNICEF 2008, 1). BEAM was a social protection programme funded by government to ensure that the vulnerable children attended school. The programme provided grants for school fees, levies and examination fees to orphaned and other vulnerable children between the ages of six and nineteen (UNICEF 2008,2). Learners benefiting from BEAM still had to meet other costs including uniforms and stationery. The Ministry of Public Service, Labour and Social Welfare implemented the programme in collaboration with the Ministry of Education,

Sport and Culture and local authorities. The Beam grants were provided in addition to the longstanding administration and tuition grants allocated to registered schools.

The period 2000 to 2003 was characterised by a rise in inflation and the reduced impact of government grants. The main response by school authorities was to access the grants quickly and apply them before they were eroded by inflation. Finance houses still offered interest rates that were considerably higher than the inflation rate. In that regard, schools would get the government grants, invest in high interest yielding accounts for a period of six months or more, and still be able to purchase more with the capital plus interest than they would have achieved with the original amount. Government grants and levies on learners were adequate and some schools even embarked upon capital development projects between 2000 and 2003. In response to increasing rates of inflation, schools reviewed fees and other charges in line with inflation rates and mostly one review per year.

Schools indicated that after 2003 BEAM grants became a less significant source of support for the schools. By 2007, inflation had eroded the value of BEAM grants. The grant turned into an administrative burden, requiring much more input and yielding little income for the schools. A teacher at Mushipe Primary school referred to BEAM as a *Chikwambo*, a mythological magical charm acquired to bring wealth, good luck or relief but ending up invariably demanding more than the benefits it brings and also being impossible to dispose of. In essence, though the BEAM grants were designed to bring relief to the individual learner, they were increasingly becoming a huge expense to school instead.

The period between 2004 and 2006 witnessed sharply reduced government funding for education as the government increasingly depended on domestic borrowing to finance its budget deficit. In order to meet the shortfall in government funding, schools effected frequent increases of fees, ending up with an increase each term. As few ordinary level graduates could afford the high fees at advanced level boarding schools, the community successfully used the collective voice pressure politics and lobbied central government

for the establishment of advanced level classes at the cheaper council day secondary school. At Kanongovere secondary school, advanced level classes began in 2006. There was no new classroom space for the advanced level for the classes leading to acute overcrowding. The three primary schools in Maotsa had also not managed to raise funds for the construction of classrooms for the recently established grade zero.

Faced with an astronomical rate of inflation, in a populist bid to protect the citizens against inflation and ‘profiteering’ by business and service providers the government instituted a wide range of price controls including regulated increases in schools fees. All school authorities were required to obtain written ministerial consent before effecting any change in school fees and levies. This was against a backdrop of the reduced value of government grants due to high rate of inflation. Schools responded to the regulation by applying projected inflation rates to peg the proposed school fees rates. Due to delays in the release of official inflation figures, the estimated rates were invariably higher than the official rate²⁹. The Ministry of Education, Sport and Culture would invariably revise downwards the proposed increases in school fees basing revised figures on the actual official inflation rate. When the decision on approved fee structure was finally communicated to schools, the fee levels would be inadequate, having been eroded by inflation, hence the constant requirement for fees and levies ‘top ups’.

In 2007, the Zimbabwe economy hyper inflated and increases in fees became more frequent. Serima secondary school, a high fee boarding school in Maotsa opened the third and final term of 2007 with a fee structure of Z\$4 million per pupil per term. Four weeks into the term, the school demanded an additional Z\$35 million per learner. Four weeks before the end of a thirteen-week term, they demanded Z\$450 million to complete the term. The steep and sustained increases in school fees were buoyed by hyperinflation that reached a peak of 6723,7% annually for 2007 as demonstrated in Figure 5.1. Schools also began charging for expenditure items separately, for example, charging individual

²⁹ Up to 2005, the government through the Central Statistical Office (CSO) released inflation figures of preceding month by the end of the first week of each month. Thereafter there were delays in the release of inflation figures and by 2007; the CSO habitually delayed releasing the inflation figures by at least three months.

stationery and sports fees. Despite regular increases in fees, schools struggled to meet the costs for capital development, maintenance, procurement of textbooks and stationery.

From 2000, schools had failed to replace textbooks and by 2007, several learners shared a single textbook. Mukwasi primary school had the worst student book ratio; the senior grades from grade five to seven had one textbook each for the exclusive use by the teacher. At Serima secondary school, the learner textbook ratio was maintained at 1:1 for all subjects.

Besides inadequacy of textbooks and other leaning materials, schools were adversely affected by resignations of qualified teachers from the civil service. The staff shortage was particularly acute for the sciences and mathematics subjects. Kanongovere secondary school did not offer sciences at advanced level because they lacked qualified staff and requisite science laboratory equipment. Though Serima secondary school offered sciences, in 2007 the school stopped admitting students for advanced level physics as the qualified teacher, the last one in the whole district had left the school for better opportunities in Botswana. There were no prospects of finding a replacement, qualified or not.

6.1.2 Teacher Based Strategies

At the beginning of the economic crisis in 2000, most teachers were not adversely affected at least not immediately. As noted in Chapter Five, in preparations for the 2000 general elections government awarded civil servants salary increases of 69% to 100%, well above the annual inflation rate at 55,9%. Civil servants also benefited from the land reform programme as many of them acquired land in the government-acquired farms. In Maotsa, the civil servants got some special dispensation as they were allocated land near their workplace. Government supplied farm inputs in the first two years of resettlement programme which drastically increased yields and farm income.

One prevalent coping strategy for teachers that benefited learners directly was the commercialization of the teacher's skills through conducting extra lessons for a fee. This practice was done privately at the instigation of parents and publicly, at the instigation of teachers. A parent initiated the extra lessons when the learner was perceived to be performing poorly or was in a class taking a public examination. The need for extra lessons also arose when pupils missed classes due to absences of teachers on industrial action. The extra lessons organized and initiated by teachers were usually held over the school holidays. However, in 2007 for the first time since 2000, Serima secondary failed to offer the traditional holiday revision classes due to food shortages. The school was experiencing difficulties securing food provisions as there were serious shortages and managing the voluntary school vacation programme in an inflationary environment would be an additional burden to the school authorities.

Teachers conducting private lessons charged different rates depending on their experience, expertise, level taught and subjects concerned. To protect themselves from inflation, most teachers, particularly the experienced ones with reputation of producing good results, increasingly demanded payment in foreign currency or in commodities such as grocery items, grain or chickens. Indeed, many refused payment in Zimbabwe currency as it lost value too quickly. Teachers were also more likely to exact gifts from the community in the form of grain, vegetables and milk. They bought goods from the community at concessionary prices as a sign of appreciation for their services and recognition of the low salaries they earned. The individual direct actions by parents to access individualised tutorship were complemented by the teachers' internal public exit strategies as they sought to engage in the informal economy.

At Kanongovere primary school, when the teachers went on industrial action in September 2007, a grade seven teacher chose not to join the strike and continued teaching. From discussions with the teacher, his main motivation to continue teaching despite countrywide industrial action was to have his school maintain a lead position in grade seven results in the circuit of fourteen schools. The teacher also entertained the ideal of joining a private school, a career adjustment dependent on sustained achievement

of outstanding learners' results. In appreciation of the teacher's unwavering commitment to duty, parents of the seventh grade learners contributed individually an amount that was in total worth three months of the teacher's gross salary. At Serima secondary school, the allowances for teachers were factored into the school fees and each teacher received their portion at the beginning of each term. As a result, since the introduction of allowances in 2006, the teachers at Serima secondary school did not participate in the nationally organised industrial actions.

The co-financing of teachers' salaries was achieved despite there being no public policy framework or regulation to support it. Indeed the Public Service Commission, the employer of all civil servants, prohibited teachers from receiving any emoluments without its written consent. In both Kanongovere and Serima cases, the teacher's individual interests undermined their desire to contribute to collective voice pressure politics by taking part in nationally organised work stoppages.

Teachers also showed great ingenuity in improvising learning aids. In Maotsa, teachers used the relief food containers as chart material. However, after the 2005 general elections police in Gutu arrested some teachers for allegedly using elections posters as substitute for charts well after the elections³⁰. Despite successes in income enhancing strategies, teachers could not effectively respond to the HIV and AIDS pandemic. At Mukwasi primary school, the school head indicated that between 2004 and 2006 the school grade seven results were poor because of staff attrition. The school had over three years, lost four qualified and experienced teachers due to deaths. The deaths, likely linked to HIV and AIDS complications, followed long periods of illnesses and consequential absences from duty on official and unofficial sick leave. In a study in Chivi in southern Zimbabwe, Nemarundwe and Mutamba (2008, 85) had equal difficulty attributing suspected deaths to HIV and AIDS arguing that, "it is not possible to attribute the deaths to HIV and AIDS with confidence, since the causes of deaths are not discussed openly".

³⁰ Interview with Progressive Teachers Union of Zimbabwe national coordinator held on 29 May 2008.

6.1.3 Internal Provider Exit

The internal provider exit strategy became prevalent as the crisis in Zimbabwe deepened. In Maotsa, in 2007 there was an exodus of pupils from Mukwasi and Mushipe primary schools to Kanongovere primary school. Mukwasi and Mushipe primary schools required pupils to contribute stationery whilst Kanongovere primary school had a central procurement system. Kanongovere primary school had better facilities and consistently produced better results than the other two. In 2004 and 2005, it had maintained the second best position in grade seven results in a cluster of fourteen primary schools. Learners' withdrawals from the two schools had a debilitating effect on the schools exited. Reputation of schools went down and as enrolments figures dropped so did the number of teachers. At Mukwasi primary school, in a class of thirty-nine that completed the sixth grade in 2006, only twenty-three remained in grade seven by the end of the first term in 2007. Of the sixteen learners who sought transfer from Mukwasi primary school fourteen were enrolled at Kanongovere primary school and only two left the district altogether. Total enrolment for Mukwasi primary school dropped from 298 to 265 between the two terms. Mushipe primary school also lost 13 pupils to Kanongovere primary school during the same period.

As a direct result of withdrawal of learners, Mushipe primary school faced the prospect of losing a teacher as its learners enrolment had from 2006 to 2007 declined to 225, below the 240 required to maintain six teachers. The Ministry of Education, Sport and Culture allocated teachers at the rate of one teacher for every forty pupils. The effect of reduced number of teachers was that some teachers would take more than one class, a strategy that was less effective and burdened the teacher. Interviews with teachers revealed that having two grades taught by a single teacher compromised the standard as timetabling and delivery for two classes was difficult. Mushipe primary school head relied on the tardiness of the Ministry of Education, Sport and Culture district officials to maintain the establishment of the six teachers. In terms of the exit framework, the internal provider exits were relatively massive and did not allow the schools to recover. The internal provider exit also made the poor performance apparent to the less quality

conscious parents who would otherwise not have noticed the decline if there were no massive exits.

6.1.4 Leveraging External Support

The declining government grants and reduced local revenues led schools to initiate strategies to access external aid and produce the services previously provided by the public sector. At Mukwasi primary school, a former pupil who was then a lowly paid civil servant in the capital in 2005 donated the only soccer ball in use. The former pupil's interest arose from his captaining the school soccer team for two consecutive years when he attended the school in late 1960s. In this case loyalty to the school promoted externally supported direct action. At Mukwasi primary school, the headmaster's cousin based in the United Kingdom had also donated the new set of textbooks in 2005. In that case, family relations were exploited to the ultimate benefit of the community. There were three isolated cases where families cared and paid for the education costs of children not blood relatives but only related through attending the same church. Though some of the individual and once off donations were small, they were significant to the operation of the school and learners concerned.

In Maotsa, among the many pressing issues requiring external intervention was the lack of food. The community largely depended on humanitarian aid on a year-to-year basis, as it was located in a perennial cereal deficit area. As the economic crisis deepened, there were food shortages and in early 2006, the community leaders negotiated that the food aid be extended to primary school learners. The request was made against declines in enrolments and higher rates of absenteeism as learners opted to search for food rather than attend school. Beginning in 2006, the humanitarian agencies provided school learners' with lunch. The school feeding programme provided morning porridge for infants and lunches for all pupils. The introduction of the feeding scheme resulted in an immediate increase in enrolment and improved school attendance. However, by 2007 the increased learners' attendance inversely matched the teachers' absences due to perennial industrial actions.

The schools benefiting from the food aid upon discovering the problems some of the learners faced in caring for bedridden parents or guardians after school allocated the pupils with prepared food hampers for their ill parents or guardians. The aim of the scheme was to reduce the burden the learners encountered when caring for their parents or guardians. After being in practice for a term this food hamper scheme was put forward as a proposal that was quickly accepted by the donor who factored in allocations for such adults.

One condition put forward by the donor for the schools feeding programme, was that the schools erect a billboard indicating that the United States Agency for International Development (USAID) sponsored the school-feeding scheme. The local leadership particularly the councillor and ZANU-PF women's league representative who was also a member of the provincial ZANU-PF structures were against such a billboard. At a time immediately before a general election, the billboard with the mention of USAID was unpalatable given the ZANU-PF and central government rhetoric regarding the 'imperialist motives' of Britain and United States³¹. The community reluctantly but tactfully accepted the donor's conditions and billboards were erected.

The infusion of donor support and the conditionality attached to the food aid programme, negatively affected the application of traditional instruments employed by school authorities to exact payment of fees and levies arrears by pupils. The school authorities could not use the traditional technique of excluding learners from school for non-payment of fee, as the school feeding programme required that all pupils got meals every schooling day for a school to remain on the programme. As a result, the school heads resorted to a less effective method of excluding pupils in small batches beginning with the examination classes. In any event, excluding learners for non-payment of school dues had little effect as most pupils 'sent home' hid in the nearby tree plantations only to resurface during the feeding hour.

³¹ The ruling ZANU-PF party insisted that the travel ban imposed on its leadership by the European Union and United States were 'illegal' and smacked of neocolonial patronage by the former colonial master.

In Maotsa, the donor providing support for the school-feeding scheme provided security personnel to safeguard the food provisions. The schools negotiated with the donor for the mandate of the guards to be extended to safeguard the whole school premises³². The appointment of guards immediately reduced thefts and pilferage from schools. In this way, the communities were taking advantage of external support to provide security service that the state ought to have provided.

6.1.5 Local Communal Direct Action

Between 2000 and 2003, the main strategy by schools to maintain financial solvency was to augment government grants by getting as many contributions from learners as they possibly could. The schools development committees adopted exclusion policies for non-payment of fees to encourage early settlements of dues. Fees collected could still be invested in high interest yielding accounts. Encouraged by the positive interest rate regime offered by banks and finance houses, some schools began levying for separate capital developments. In 2003, Serima secondary school successfully levied pupils and raised enough funds to purchase a 78-seater bus for the school. From the levies, the school also bought a new light van for the school. The early years of the crisis therefore gave space to those schools with savings and visionary leadership to develop further.

Up to 2003, the Zimbabwe schools examinations council (ZIMSEC) still managed to administer the exam process effectively, providing all the stationery. From 2004, learners taking public examinations had to provide their own writing material during examination, further pushing up the costs of education to the learner. Schools ceased providing learner stationery as the government grant for the purpose had been eroded by inflation. Schools had varied arrangements for procurement of stationery but in all cases, the costs were borne by the learners. Three of the five schools, Kanongovere secondary school, Serima secondary school and Kanongovere primary school, procured stationery and included the stationery costs as part of the fees. The urban centres were far and transport network poor and hence central procurement of stationery provisions by the schools became a cheaper

³² Two guards, one stationed at Mukwasi primary school and another at Mushipe primary school indicated that the donor representative had emphasised that the guards' principal terms of reference included guarding against thefts by teachers and a team of women hired to prepare the food. The two parties were suspected of being responsible for the rampant pilferage of food.

option. Mukwasi and Mushipe primary schools that had independent procurement by pupils were located nearer the major transport networks, Mukwasi primary school near a railway station and Mushipe primary school, a trunk tarred road leading to an urban settlement. The individual direct actions successfully compensated for the reduced public services.

Communities had a longstanding history of contributing towards the construction of school infrastructure. However, following the reduction in government support, communities no longer relied on government for assistance but assumed sole responsibilities over the construction and maintenance of school infrastructure. By 2007, central government was unable to respond to emergencies. During the summer season of 2007-2008, a tropical storm destroyed a section of an old classroom block at Kanongovere primary school. There was a risk of losing the whole building if the damaged section was not repaired urgently. The headmaster reported the damage to the parent Ministry of Education, Sport and Culture. The Ministry indicated that it had no funds for such projects and that they relied on assistance from the Ministry of Rural Housing and Social Amenities as regards development and maintenance of infrastructure at schools. The individual voice to bureaucrats did not yield positive results.

The Ministry of Rural Housing and Social Amenities had used up its annual allocation following numerous similar requests and was therefore unable to assist the school. The Ministry of Education, Sport and Culture district officials unable to respond advised the community to take communal direct action and mobilize resources to repair the damaged part of the building. The community did not engage the Rural District Council, which was the responsible authority for the school as they had become accustomed to the financial limitations the local authority encountered. The anticipated negative response rendered collective voice against council unviable. However, the community managed to attract some contribution from the sitting councillor who was then campaigning for re-election. The councillor donated one thousand bricks and the community contributed another two thousand bricks. Each learner contributed six bricks or the monetary

equivalent. The community also contributed other locally available building materials such as sand and water.

After contributing the bricks, the community exhausted its resources and had to rely on its wealthier members. The school borrowed twelve bags of cement from one of the village heads for the reconstruction project. The village head was to be reimbursed at a date still to be negotiated. The school development committee (SDC) also exploited the party patronage system and approached one of the aspiring ZANU-PF parliamentary candidates for assistance. The aspiring candidate pledged six bags of cement for the repair of the school. Further investigations on delays in handing over the cement donation by the politician revealed that his commitment was conditional on him winning the party's nomination, which he had lost to a rival. Members of the community volunteered the labour. The chairperson of the school development committee, a skilled builder offered labour free of charge. The forced urban to rural migration undertaken as core component of Operation Restore Order in the cities in 2005 had resulted in an abundant supply of highly skilled labour in the rural areas that was mobilised for local projects.

All volunteers working on the repair of the classroom block received free lunch. The provision of lunch in an environment where food was scarce was significant. The school authorities did not directly provide the lunch as the volunteer workers shared the food donated for learners. In responding to the decline exaggerated by an emergency, the community at Kanongovere primary school adopted the direct action strategy with individual direct and communal direct and externally supported direct actions complemented by collective voice pressure politics. They used local contributions, took advantage of political competition to demand donations, local volunteer labour and appropriated donations to respond to the challenge despite the inability or unwillingness of the central and local governments to contribute. The communal direct action by the community was consistent with observations recorded in rural Kenya where, when faced with a decline in state support, the communities collectively provided for building and refurbishment of school and houses for teachers (Francis and Amuyunzu-Nyamongo 2005, 19).

The school development committees developed strategies to ensure that the poor pupils continued to have access to education. Poor guardians and parents were in some situations given an opportunity to undertake chores at the school *in lieu* of fees. This was a common practice at all the four council schools. In an earlier study by Mwanza (1999, 52) the strategy of providing labour *in lieu* of payment of fees had been hailed as enduring. The strategy was only enduring up to 2003 and later proved less viable because it had limitations. Whilst schools needed cash to meet day-to-day expenses, labour was usually required during winter when most construction work was undertaken. At Serima secondary school, the practice of working *in lieu* of fees was minimal due to high cash requirements of the school. However, the school accepted payment of dues in commodities particularly maize and beans and large livestock such as cattle. Such provisions were scarce on the market and the school needed them for feeding the pupils.

6.1.6 Political Patronage

In Maotsa, the community traditionally relied on school bursaries offered by the former Member of Parliament (MP) who had been one of the country's vice presidents. The MP had offered full scholarships for the vulnerable particularly orphans and he generally lobbied for favourable government allocations and donations to the district. His death in 2003 and the subsequent cessation of the scholarships led to the withdrawal from school of some learners previously supported under the bursary scheme. The then Member of Parliament was less helpful than his predecessor. However, in 2006 the MP had secured donations of books from philanthropists in Europe. The MP mobilised all schools in the constituency to contribute towards the shipment of the donated books. When the books were delivered, new constituency boundaries had been demarcated and only the schools in the new constituency where the MP was to contest the parliamentary elections benefited from the book donation.

Though defrauded by the MP, the community had no access to immediate restitution through collective voice pressure politics as would be expected because of their support and fear of ZANU-PF. Party supporters regarded criticizing a ZANU-PF House of

Assembly nominee before elections as being unpatriotic and might attract political victimisation. Such victimisation was indeed likely, as the MP concerned had also become the provincial chairperson of the ruling ZANU-PF party. A candidate for the new constituency covering Maotsa donated national flags to all the schools in the constituency. The Ministry of Education, Sport and Culture required every school to hoist the national flag during working hours.

Intra-party factionalism within ZANU-PF was pronounced in Maotsa with two factions competing from the ward to provincial levels. A 2004 survey on public opinion on economic and political conditions observed that infighting among ZANU-PF elites was pervasive in Masvingo province (Bratton, Chikwana and Sithole 2005, 99). To maintain support, faction leaders had to deliver political goods. Schools were popular recipients of donations from politicians. During the 2005 Parliamentary elections, Mushipe Primary school received a grant for sinking a dip well from the Ministry of Information and Publicity. The Ministry of Information and Publicity's mandate had little reference to education but the then Minister was a leading protagonist of one of the ZANU-PF factions.

All Primary schools in Maotsa had in 2006 accessed a rural housing grant administered by the Ministry of Rural Housing and Social Amenities, whose Minister was a leader of one of the ZANU-PF factions. All three primary schools had used the rural housing grants to construct staff houses. The intra-party faction in ZANU-PF and led the faction in control to access as much public resources as possible for the benefit of its supporters.

In an interview with one member of the faction whose candidate lost the party primaries, she alleged that the winning faction had abused the rural housing grants to assist its candidates gain nomination and votes ahead of the Parliamentary elections. The factionalism in the ruling ZANU-PF party was consistent with Chung's (2006, 326) observations that the gradual decline of the state influence in Zimbabwe resulted in the emergence of regional lords drawing support and allegiances on ethnic lines. The regional lords would use this support to gain access to state positions and resources.

Within the ruling ZANU-PF party, the regional lords threatened ‘to remove their support if they were not given posts and privileges’ (Chung 2006, 326). As espoused by Hyden (2006, 75), conspicuous expenditure and general ostentation by politicians during elections was an important factor in local politics as “accountability at election time is immediate; the candidate must demonstrate personal generosity as part of the process of campaigning”.

In Maotsa, the community continued to struggle to pay the annual lease fees to council. Asked why they continued to pay dues to a council that failed to meet its obligations the respondents indicated that they were avoiding conflict with government and would rather pay than be labelled renegade. The community remained supportive to the ZANU-PF government and local authority because of fear of repercussions arising from challenging the regime. It was an instance where fear-induced support to ZANU-PF undermined the development of voice. The existence of active ZANU-PF factions led to an emphasis on party discipline and intolerance to dissent. However, the community took advantage of the competition between factions during elections and used collective voice pressure politics to claim services from the ruling party.

6.1.7 Helplessness and Apathy

One common perverse response was the forced selling of assets. Families often sold assets to meet the cost of education. An example was that of an octogenarian widow caring for orphaned grandchildren in Maotsa who in November 2007 attempted to sell a steer to pay for the cost of exercise books, school fees arrears and uniforms. After getting a buyer in local currency, she could not locate a foreign currency dealer to convert the remainder of sale proceeds into South African rand or United States dollars and so had to cancel the sale. Instead, the widow opted to sell her maize grain despite the obvious risk of starvation given the poor harvest following flooding that had affected crops the previous farming season. The widow actually relied on relief aid for food handouts and hoped the food handouts would continue into the next harvest.

This was consistent with Pankhurst's (1988) finding in Murewa when communal farmers sold food crops to gain cash despite not having any surplus. The poorer member of the community encountered problems in disposing assets especially livestock for they would be inadequate in the first instance. The Zimbabwe Human Development Report (PRF 2003, 95) asserts that reduction in the herd size further negatively affected draught power and led to lower agricultural yields.

Occasionally teachers appropriated food donations meant for learners. In Maotsa, teachers partook in lunches donated for learners by an international aid organisation. Teachers at all three schools benefiting from the feeding programme invariably got some 'leftovers' for supper.

Schools reduced costs by not issuing receipts for payments made. By 2005, the cost of a single leaf of a receipt book was often more than the term school fees; hence, issuance of receipts meant spending far more on administration than the total amount receipted. Despite being a practical means of coping with high administration charges, the ultimate costs of such measures was the loss of an audit trail and increased opportunity for misappropriation.

Parents sought cover against the full impact of inflation by purchasing school provisions such as exercise books and writing pens for their children in bulk. The strategy was longstanding and enduring for a few who could afford it.

6.2 Health

In Maotsa, the clinic operated by a Roman Catholic Church was first established in the early 1950s and had developed over the years. Infrastructure at Maotsa clinic was of a relatively high standard. The 28 patient beds Maotsa clinic had better facilities than the standard rural health service centre. The clinic had four wards including the maternity ward, the female, male and intensive care wards. Maotsa clinic had two consulting rooms, a treatment room, a dispensary, two offices, a kitchen and a mortuary. The clinic had access to grid electricity and reticulated water. Potable water was supplied from two

boreholes. A diesel engine powered one of the borehole pumps so the clinic was guaranteed water even during periods of prolonged grid power outages, unless diesel was also unavailable. Water for other commercial uses such as laundry and irrigation was supplied from a dammed reservoir. Maotsa clinic supplied food to all hospitalized patients. The clinic had a full staff compliment for the period under study. In Maotsa, the referral hospital had usually at least one doctor out of an establishment of five. The better-stocked and staffed referral hospital in Maotsa operated at over 100% bed capacity from 2000 to 2007.

The clinic in Maotsa had an HIV and AIDS voluntary counselling and testing (VCT) facility. The Catholic Development Commission (CADEC) and the Global Fund to fight HIV, AIDS, TB and malaria funded an active ART and VCT programmes. There was no waiting period for those requiring antiretroviral treatment. The opportunistic infections (OI) clinic was vibrant. Patients in Maotsa did not have to pay for cluster of differentiation 4 (CD4)³³ count and liver function tests in preparation for the initiation of ARVs. After a campaign in December 2007, thirty-eight people joined the programme following a month of testing and counselling. The referral hospital for Maotsa also ran a relatively well-stocked former TB sanatorium. The concurrence of TB and AIDS meant the referral centre was primed for the task.

In Maotsa, there was evidently open discussion about the HIV and AIDS pandemic with many people living positively with HIV willing to share their testimonies. Patients on ART in Maotsa openly spoke about how *Chirongwa* (the programme) had saved them after facing imminent death. However, despite the ease of access, some HIV and AIDS sufferers only sought medical intervention when seriously ill and some were too ill to be put on ART.

33 A person's CD4 count is the number of CD4 cells in a small amount of their blood (written as the number of cells per cubic millimetre, or mm³). One can have a CD4 count test. CD4 cells are part of one's immune system; the cells that help fight infections. HIV destroys CD4 cells. The fewer CD4 cells one has the more damage HIV has done to their immune system. People who do not have HIV normally have about 1,000 CD4 cells per cubic millimetre of blood. As the number of cells falls, one is more at risk of getting certain infections and types of cancer (BMJ Group 2009).

The landline telephone at Maotsa clinic had been down since early 2005. The telephone cables had been vandalised during the violent occupation of commercial farms by the 'new farmers' resettled in the adjoining commercial farms under a government sponsored land reform programme.

6.2.1 Collapse of the Primary Health Delivery System 2000-7

In Maotsa, of the eight village health worker (VCW) trained, none was still active in 2007 as three had died, two resettled outside the ward, beneficiaries of the government initiated land reform programme. The remaining three stopped working when inflation eroded their allowances and they no longer received first aid medical kits. Without government support, continued operations by the VCW would have entailed them subsidising the programme.

The Ministry of Health and Child Welfare procured and distributed drugs to all clinics and rural health service centres through a government company, the National Pharmaceutical Company of Zimbabwe (NatPharm). However, from about 2000, the drug deliveries by NatPharm became erratic. The rural health service centres were also eligible to receive two types of grants from central government: a recurrent grant to cover the costs of general administration and a medical grant to cover the costs of medical supplies. Over time, inflation had eroded the value of the grants and in 2007, Maotsa clinic received an allocation of Z\$48 million for the entire year and by March 2007 the grant was fully spent as prices had risen drastically in sympathy with the high rate of inflation.

Throughout the period under study, the Maotsa clinic typically had in stock the basic drugs required for a rural health centre. The Catholic administered clinic received substantial donations of medical supplies and support from the referral Catholic hospital. Despite having multiple sources of medical supplies, the stock levels were much lower from 2002 and increasingly the clinic prescribed antibiotics only to seriously ill patients.

In Maotsa, patients faced serious transport problems when transferred from the clinic to the next referral levels. The ambulances had long ceased to function because of the collapsed road networks, non-maintenance of vehicles and the resultant breakdowns, and lack of fuel. The bus company plying the route connecting Maotsa clinic and the referral hospital had ceased operating in 2004.

Maotsa clinic owned a truck donated by the Catholic Gweru diocese in 2001. The truck doubled as an ambulance and delivery van. The local Catholic diocese also met the maintenance costs for the vehicle. The weekly Extended Programme of Immunisation (EPI) outreaches relied on the vehicle. When patients used the clinic 'ambulance' for hospital transfers, they paid a nominal fee to cover the cost of fuel as the diocese did not provide for fuel. The Maotsa clinic truck broke down in mid November 2007 and required major repairs. The Catholic diocese was by December 2007 having difficulty raising sufficient funds for the required gearbox overhaul for the vehicle. When the vehicle was operational, again the clinic still faced problems procuring fuel. They had last received the fuel allocation from the Ministry of Health and Child Welfare in August 2007. By December 2007, the clinic had still not managed to get transport to take delivery of porridge donated in early November 2007 by the diocesan centre about 130 kilometres away.

6.2.2 Exit

Internal public and provider forms of exits were observed in Maotsa. Patients went to Hama mission hospital about 70 km away in the neighbouring Midlands province when they failed to access services at the referral Catholic hospital. Hama hospital was the nearest hospital offering full diagnostic services for HIV and AIDS, including the liver function test and CD4 count. A few civil servants, businesspersons and pensioners relied on private health service providers based in the neighbouring city, Masvingo.

Migrant workers who fell seriously ill in urban areas often returned to the rural areas for a cheaper and more reliable health service. The trend was prevalent due to the high incidence of HIV and AIDS. The increased demand for health services by returning migrant workers further congested the health facilities.

6.2.3 Communal Direct Action

A local clinic committee comprised of representatives from nursing staff, local councillor, headman, representatives of home-based caregivers and traditional medical practitioners provided support to the clinic. The clinic committee facilitated participation of ordinary citizens in health delivery matters and was a communication channel, mostly conduit and filter of grievances between the clinic authorities and the community. The local clinic committee was crucial for setting consultation fees and other contributions from the community. It did not have any budgetary powers and was informed about government grants and other donations only to demonstrate the inadequacy of income and the need to raise the fee rate. The clinic committee was however an effective way of managing the collective voice pressure politics process.

In Maotsa, the costs for support staff including security were borne by the Catholic Church that operated the clinic. In the post independence era, the Maotsa community was also never required to contribute towards the development of infrastructure at the clinic.

The decline of the public health delivery system and the increase in HIV and Aids burden resulted in terminally ill patients taken care of at home. The Ministry of Health and Child Welfare's response to the decline in health service delivery was to encourage the communities and families to be involved in care for the ill. The home based caregivers (HBCs) were active in providing the essential services to bed-ridden patients. The HBCs got support from donors who provided essential supplies such as latex gloves, painkillers, soap and wound ointments. However, equipment and supplies, particularly of painkillers and latex gloves, were in short supply. There were reported cases of burnout, as caregivers served many patients and did not receive any allowances. Without adequate

support, the community and home-based care programme resulted in the abandonment of the terminally ill patients for, 'home neglect' (PRF 2003, 156).

The church prayer groups for women and men played a critical role in the provision of health. Members of the same faith offered each other psychological and material support during periods of illness. They also helped with other household chores like fetching firewood, tending to fields and livestock. This type assistance emphasised horizontal cooperation between members of the community.

6.2.4 Leveraging External Support for Direct Action

Different segments of the community accessed varied types of external support to compensate for the decline in government provided services. The clinic attracted both national and international donors. In Maotsa, the clinic utilised its Roman Catholic connections to access external resource actors. As a result, in Maotsa the problem of shortage of medicines was not acute because the mission clinic relied on its Catholic links to procure medicines. Some medicines were donated from European based friends of the church and some by the referral hospital, also ran by the Catholic Church. The Clinic in Maotsa benefited from an outreach programme for HIV and AIDS patients managed by the Catholic referral hospital. Medicines and related supplies meant for treatment of opportunistic infections among HIV positive patients (OI), especially cotrimoxazole were used to benefit other HIV negative patients. The anti retroviral therapy (ART) programme in Maotsa also benefited from USAID food handouts for feeding the patients.

The community also sought to maximise access to free health (at the point of consumption) from all external sources. In Maotsa, there was a case where the son-in-law of a prominent village head in the area was a medical doctor and members of the surrounding villages took advantage of his regular visits. Whenever he visited his family, people inundated the home of the village head to consult on various ailments. He worked for a private company and usually moved around with essential drugs that he dispensed sparingly to a select few.

Clinics relied on relations established with other local service providers to access scarce supplies. Health institutions habitually lent and exchanged among themselves medicines and sundries in short supply. Medicines became fungible assets exchanged with the cluster of health service providers for other drugs or future favours. In Maotsa, the local clinic in August 2006 supplied the government operated district hospital two cartoons of latex gloves for onward redistribution to all the rural health centres in the district. The clinic had in early 2007 supplied its sister Catholic referral hospitals with bandages. Clinics used such donations to exchange for any medicines that the recipient had in quantities greater than the emergency levels. However, this free movement of drugs between health centres made auditing difficult.

6.2.5 Reordering of Health Service Provision

The clinics responded to the decline in support by reordering the service provision structure as a means of directly offering the service. Reduced levels of funding and lack of medicines and health personnel resulted in many health institutions being unable to offer basic services expected for their levels. Referral centres could not always accommodate patients requiring specialist attention. The health institutions responded to that challenge by re-organising the service and functions that each level had to provide. The local medical staff implemented the reordering of functions of health institutions at the local level with active complicity of health personnel at district and provincial levels and tacit approval from the Ministry of Health and Child Welfare. The reordering usually entailed that a lower level institution provided services and care normally prescribed for a higher-level institution whilst some referral centres gave primary health care services.

In Maotsa, when the clinic staff undertook the weekly immunisation outreaches, they carried other essential drugs with them and treated adults with many ailments including referring cases to the hospital. Such services were critical for the aged and infirm who had special difficulty accessing the clinic. When the doctor from the referral catholic hospital came to the clinic on HIV and AIDS outreach programmes they would leave behind some drugs to treat opportunistic infections. As a result, the clinic ended up dispensing drugs above its regulated levels. The clinic routinely dispensed steroids, and

painkillers that were classified by the Ministry of Health and Child Welfare as drugs to be prescribed by and administered under the care of a registered physician. One of the direct effects of dispensing higher-level drugs was to attract patients from outside the catchments area who quickly noticed the difference in the quality of medicines provided by Maotsa clinic compared to those supplied by government or council administered clinics.

The Catholic-run clinic in Maotsa developed separate reporting and referral systems not necessarily consistent with Ministry of Health and Child Welfare guidelines. By government guideline, patients from Maotsa requiring specialist services were referred to District hospital in Gutu, the district administrative centre. However, the clinic did not refer patients to the government district hospital that usually had no doctor on duty. Patients who approached the government district hospital were further referred to a nearby mission hospital that had doctors. Patients from Maotsa were therefore referred to a Catholic hospital in a neighbouring district and falling under a different administrative province.

The clinic in Maotsa as informed by the Catholic doctrine did not offer contraceptive services as part of health care. The clinics had only begun distributing condoms from 2004 as a disease prevention measure and not for birth control purposes. The clinic was not dispensing some of the basic services to promote primary health care as per mandate of the Ministry of Health and Child Welfare. However, staff at the clinic occasionally gave contraceptive injections if the patient brought their own medicines. A nurse, not a nun would administer the injections or the consultation regarding birth control.

The home-based caregivers (HBC) volunteers though not part of the civil service increasingly assumed functions previously performed by VCW. Over and above caring for bedridden patients, the HBC givers also reported any unusual community deaths in the villages and advised ill people of the treatment options available at the health centre.

In Maotsa, the Roman Catholic hierarchy was strictly observed. Complaints were channelled to the priest through the local guild committees. Church services were a major medium of communication including on health matters. In 2005 when there was an anthrax outbreak, the regular guild meeting and Sunday masses became the space for disseminating information about the epidemic. It was therefore beneficial to become a loyal member of such a system.

6.2.6 Self Medication

Some of the patients who failed to access medicines at clinics and could not afford private care resorted to self-medication. The strategy was a direct action by individuals to provide services as patients self-diagnosed and embarked on a drug regime outside supervision of qualified health personnel. The practice was on the increase and took varied forms. Some respondents reported using drugs left over by relatives. In any event, the poor storage and consequent safety of the 'hand down' drugs became questionable. The use of leftover medicines was prevalent with wound ointments, cough mixtures, painkillers, intravenous drips, bandages and latex gloves. The use of medicines handed over by friends or relatives was prevalent although these medicines had not been prescribed.

Some elderly patients preferred self-medication to following the rigors and 'insensibilities' of the public health delivery system. Older patients were not appreciative of the procedures at public institutions such as a western diet among others. In Maotsa, a 97-year-old widow in reaction to previous ill treatment at hospital refused to go to clinic when she fell ill. She however demanded that her grandchildren buy her the medication rather than that she expose herself to humiliation.

6.2.7 Traditional Medicines and Herbs

In the absence of cough medicines, health professionals advised patients to prepare traditional concoctions such as boiling eucalyptus, guava leaves and lemon for treatment of mild coughs. The situation was similar to that experienced during the liberation war and there were similarities in coping strategies. Describing the situation in Ossibisa, a Zimbabwean women guerrilla training camp in Mozambique in the late 1970, Chung

(2006; 193) records, “medicines themselves were in serious short supply. Because of this we began to utilise some of the natural medicines around us including eucalyptus leaves boiled in water as cough mixture”.

Some respondents in Maotsa reportedly used herbal medicines in place of contraceptives because the local Catholic clinic did not offer contraceptives. In Maotsa, an asthmatic woman reportedly failed to take her recommended medicines because she was using spiritual healing and divination but she came repeatedly in an emergency for medical assistance. She would comply with medication regime whilst hospitalised and when discharged resorted to prayer and divination. That cycle reportedly went on with at least three emergency admissions every year.

6.2.8 Perverse Coping

Some patients resorted to forced asset stripping to raise funds for the more expensive private health services. In the words of a village head in Maotsa, a sentiment shared by many during interviews, ‘*Zvipfuyo ndizvo zvapera, panofa munhu neugwere mombe ndidzo dzinotungamira*’ meaning that household artifacts are not spared from stripping in times of dire need due to prolonged illness. The Human Development Report (PRF 2003, 86) also established that asset stripping to finance chronic illness arising from HIV and AIDS was prevalent in Zimbabwe.

Some patients reported delaying or not seeking medical treatment when it was actually required. It was often necessary to bribe officials in order to access the few drugs available. Patients reported ‘voluntarily’ giving nurses ‘gifts’ in the form of vegetables, fruits and grain in order to receive adequate care. The exchange of a bribe for services was consistent with observations made in the transition economy of Moldova when patients had to bribe health officials with food and cash in exchange for being looked after (De Soto and Duduwick 2003, 341). This was also similar to observations by Bates (2008, 105) who on commenting about corruption of soldiers in a failed state argues, “Like doctors and nursing aides, they sold services to which the citizens were formally entitled. Most commonly, they regulated access to public thoroughfares”.

6.2.9 Helplessness, Apathy and Substitution

Many patients referred from clinic to the district hospital for specialist care failed to get transport to the hospital and ended up relying on self-medication and other home remedies. In Maotsa, one needed oxen in good health to undertake the 35 km journey to the referral hospital. A few farmers who had strong donkeys that could undertake the 35 km trip hired them out for a fee. Some patients walked the 35 km journey to the hospital. Even the journey by train involved at least 17 km of walking. Since the condition of most patients deteriorated during the long journey, by November 2007, the referral hospital began discouraging patients from Maotsa against using animal-drawn carts as a mode of transferring patients requiring specialist attention. Some patients failed to raise the money required for transport costs to the referral hospital and stayed at home helplessly hoping for natural recovery or waiting for eventual death. Wheelbarrows were also routinely used to cart patients to the clinic.

There was also prevalent use of expired medicines at Maotsa clinic. All the *povidone-iodine* solution (for the treatment of wounds and skin infections) in use by December 2007 had expired in June 2006. The medical staff however claimed that clinical evidence proved that the medicines were still potent despite being well beyond 'use before date'.

There was a shortage of stationery particularly outpatients cards at the clinic and district hospital. Patients were required to provide their own stationery in the form of A5 size exercise books. The small books would inevitably contain the recent medical history of a patient. This became crucial because when the nurses prescribed medication they would be aware of what the patient would have been prescribed by the doctor if they had been referred to the district hospital. The system entailed that the patient had the responsibility of maintaining part of medical records and in a way freed the already congested health system from the onerous task of detailed record maintenance.

6.3 Cross Cutting Responses

The last two sections presented community responses to the decline in education and health services in Maotsa. This section presents responses that cut across and extend beyond education and health. Migration and electoral processes were analysed as crosscutting strategies that affected health and education and other livelihoods aspects. External exit in the form of migration emerges as the single most potent and significant crosscutting coping strategy. The study traces the nature of migration and its effectiveness as a response to the decline in the provision of health and education services. The application of collective voice voting as a strategy for negotiating political change and ultimately reversing the decline in the social service provision is also explored.

6.3.1 Migration

Migration in Zimbabwe involves three types of movements: from rural to urban, from urban to rural and emigration. Traditionally, Zimbabweans moved from rural to urban areas in order to access better public services. The second type of migration involving people moving from urban to rural areas upon retirement was a long established coping mechanism in Zimbabwe but became pronounced following the land reform programme that provided access to arable land to farmers and the 2005 'Operation Restore Order' (*Murambatsvina*). 'Operation Restore Order' effectively destroyed urban livelihoods in the informal sector precipitating premature movements from the urban to rural areas. The continued decline in the real wages and the high inflation rates also made the urban sector formal employment less attractive. The post-2005 wave of urban to rural migration was in a way forced migration as the people previously surviving in the informal sector found themselves unable to cope with the costs of the urban life (Tibaijuka 2005). For those whose livelihoods had been destroyed by the Operation, the rural areas offered relatively cheaper and more accessible health and education services.

The migration between rural and urban areas was therefore two directional. As the decline in state services continued, some urbanites retreated to their rural homes in order to reduce the costs in the urban areas. Yet when the crisis deepened, the rural dwellers tend to move towards the centre. Rather than being random, the rural–urban migration in Zimbabwe was similar to observations in Kenya (Francis and Amuyunzu-Nyamongo 2005, 16) and followed long established movement routes and patterns. Migration from urban to rural areas after 2000 had an effect on the exercise of voice by rural communities. Following massive urban-rural migration in 2005, the rural areas gained a critical mass of the electorate sympathetic to opposition politics having recently suffered at the hands of government policy and having experienced the brutality of its coercive elements during Operation Restore Order. For the first time, the opposition established a strong foothold in the rural communities. The option of collective voice to policy decline became a realistic alternative for the rural communities.

The third form of migration involved the complete self-removal from a failing political system to a different political jurisdiction perceived to offer better public goods, including health, education and basic human rights.

The option of emigrating was only accessible to a few empowered citizens. Outmigration to the United States (US) and Europe required migrants to satisfy stringent immigration requirements. The costs for relocation were exorbitant being at least US\$1000 for processing visa documents in addition to the airfares. Due to the higher entry costs only the highly skilled with requisite savings easily migrated to the north. Specialist medical professionals whose skills were in demand in the northern continents moved to the United Kingdom, US, Canada, Australia and New Zealand. The young generation capable of investing in training in new careers also formed a large component of emigrants to Europe and the US. This younger generation born after independence in 1980, had no special attachment and loyalty to the ruling ZANU-PF party as a nationalist movement and its government and was thus more prone to migrate. Entry and settlement by new migrants was facilitated by the fact that English was the official language in both source and destination countries. Having a member of the family established in those

countries facilitated easier access to loans and grants for airfares and assured board upon arrival. Some of the skilled personnel leaving Zimbabwe, mostly teachers, migrated to neighbouring South Africa and Botswana.

Short-term travel to South Africa and Botswana was favoured due to their accessibility. Botswana did not require visas for Zimbabwean citizens whilst civil servants were granted visas at the port of entry into South Africa upon production of a current pay slip and letter from the head of workstation confirming their employment status. Owing to this easy access, teachers and nurses were reputed to be cross-border traders into South Africa and Botswana. Following the removal of visa requirements to enter Mozambique from 2005, more Zimbabweans legally turned to Mozambique as a commodity source country.

Teachers bought goods in short supply in Zimbabwe from the neighbouring countries for resale in Zimbabwe. Indeed, at all the five schools surveyed there was at least one teacher active in cross-border trading at each school. Civil servants used their workplaces as platforms for trading. The nurses sold goods at hospitals targeting colleagues and patients as customers. The teachers supplied schools and pupils with most of the stationery sourced from South Africa and Botswana.

At Mukwasi primary school, the teachers had developed a system of covering for those absent on trading sojourns. Cross-border teachers would have colleagues take turns in attending their classes. In turn, the migrant teacher took orders from fellow teachers and delivered goods at cost price. If the trip abroad was prolonged, free gifts were given to the school head and the colleagues who would have taken over teaching the teacher's class during their absence. Despite being active participants in informal cross border trade, civil servants remained present in the formal sector. They needed the public sector employment to access entry into foreign lands and as a ready market for imported goods. There was therefore a symbiotic relationship between the formal and informal economies. In responding to decline in the value of public sector salaries, civil servants simultaneously employed engagement and disengagement strategies.

The young and unemployed that out migrated usually resorted to illegal routes of entry into South Africa. This is because they could not raise the funds required for passports and visas. The young men and women from Maotsa, being located nearer the southern border of Zimbabwe viewed South Africa as a prime destination.

Women played a key role in short-term travel, trade, or work. Since the attainment of independence in 1980 and consequent greater ease of movement, women bought or made handcraft products in Zimbabwe for resale in South Africa and Botswana. On return trips, the women traders brought goods or foreign currency for resale in Zimbabwe. This increased involvement of women was described by Francis and Amuyunzu-Nyamongo (2005, 21) as 'demasculation' of migration as women entered space previously mythologised as the preserve for men. Elderly citizens on the other hand were constrained by their physical limitations in accessing migration from Zimbabwe as a coping response.

However, as the younger generation settled in foreign lands, the older generation was increasingly travelling for shorter periods to access health facilities that were unavailable or too expensive in Zimbabwe. There were increased cases of elders going on 'medical holidays' to the city and South Africa. In Maotsa, there were two families that had a son and a daughter respectively who had settled in South Africa. The widows who headed these households frequently travelled to South Africa for medical treatments and on occasion remained abroad for six months. The widows belonged to the non-poor category, one having been married to a headmaster and businessperson, another to a teacher and former councillor for the area. The widows had until their discovery of escape routes played an active role in women's clubs in the area. The availability of the 'medical holidays' resulted in these widows withdrawing from the community activities thereby depriving the community of an essential input into collective voice by the quality conscious and empowered members.

Remittances from migrants were critical in accessing health and education services. The Zimbabwe Human Development Report (PRF 2003, 14) confirmed that due to parallel market premiums, small amounts of foreign currency could when exchanged for Zimbabwean dollars yield significantly larger amounts. The levels of remittances in the case areas were significant. Remittances resulted in the increased income for recipients and played a crucial role in the livelihoods of families in Zimbabwe (PRF 2003, 11). From interviews, people generally acknowledge the role of remittances in education and health. As one octogenarian woman in Maotsa quipped, “*Kana usina diaspora yacho ukagwara wafa*” meaning that without remittances from outside the country one cannot afford the costs of more reliable but expensive private medical services. There was reluctance to disclose the actual amounts remitted due to several factors.

Firstly, levels of remittances were not openly disclosed to avoid penalty by the state as the transfers were mostly through illegal routes. Most of the remittances from the diaspora were received through the ‘grey routes’ as there was a marked difference between the official exchange rate and the invariably higher rates offered by the illegal parallel markets. The illegality of the methods of transferring remittances and consequent need for caution led to understatement of the amounts received from the diaspora. A study on remittances sent by Zimbabweans, (Maphosa 2009, 19) established that the undocumented migrants use informal channels rather than the formal ones to transfer remittances to Zimbabwe.

Secondly, in general, personal income was not disclosed in order to minimize cultural obligations to relatives and neighbours as the known existence of ‘spare’ resources invariably attracted requests for assistance. Thirdly, consistent with Maphosa’s (2005;18) findings in a study of the impact of remittance in southern districts of Zimbabwe, some recipients of diaspora remittance could not disclose the level of remittances for fear of exclusion in international aid and government implemented public assistance programmes. Furthermore, many respondents after 2006 were increasingly receiving goods instead of cash from the diaspora.

A few families migrated from very poor and poor categories to non-poor categories after receiving remittances. In Maotsa, there was an example of a widow previously in the very poor category and reliant on aid for survival, who gradually moved into the non-poor group as she accessed remittances from the diaspora. Her grandchildren had begun migrating to the diaspora from the late 1990s and by 2005; she had nine grandchildren and great-grandchildren in the United Kingdom, three in the United States, one in South Africa. In 2003, the widow acquired an urban property from remittances and lived in her new urban home for at least five months of the year. She would also travel to the city for regular medical checkups by private services providers. However, not all migrants remitted earnings back home. The young, unskilled and undocumented migrants in the neighbouring countries were reported to be contributing very little, if any, in their first two years away.

Whilst some families benefited from remittances significantly, other members of the community did not. There were families, particularly the child and elderly-headed households that did not have access to remittances at all. These child and elderly-headed families were prevalent due to the impact of the HIV and AIDS pandemic. To such families, out migration was an unlikely option, as most struggled to access basic food requirements let alone more expensive travel documents. Therefore, when successful, outmigration was a viable individual response to public policy failure but did not constitute a viable and sustainable societal response to the failure of public services.

Teachers in specialist subjects such as mathematics and science, traditionally in short supply in Zimbabwe and in high demand in neighbouring countries left in huge numbers affecting delivery of quality education. In Gutu district in which Maotsa is located by end of 2005, only one teacher qualified to teach Physics up to advanced level remained in the entire district and was stationed at Serima secondary school. His departure for Botswana in late 2006 left his classes stranded. As a response to the situation, the school resolved not to enroll new advanced level Physics students in 2007. When on vacation from Botswana, the Physics teacher who had resigned from the school returned to Serima

secondary school and offered private lessons for a fee, charging in South African rand and United State dollars.

6.3.2 Collective Voice via Electoral Process

Many Zimbabweans ‘stayed put’ in the face of mounting hardships caused by the decline in public services. They resorted to voice to register dissatisfaction with the low quality of service. Despite taking individual and communal direct actions to access services that the government could no longer provide, more citizens recognised that the problem of poor service delivery was caused by government policy, actions and inactions. Citizens linked the economic implosion and the resultant decline in public services to the policies of the ruling ZANU-PF party. During community meetings, some members used individual voice and openly complained about the poor quality of service, particularly the lack of adequate medicines in clinics and hospitals and the perennial strikes by teachers. From 2000, the opposition MDC increasingly gained support and increased its margins of support with each succeeding election. Reduced support for ZANU-PF was also testimony of collective voice voting against perceived poor delivery by the party and government. A thirty-seven year divorcee in Maotsa had this to say,

My grandmother could read the bible, my father and mother write their own letters, I only quit school after repeated attempts at ordinary level, now someone wants to condemn my eight-year daughter to a world of illiteracy, I will not allow it. I feel obligated to respond in a decisive manner.

The deepening crisis translated into a stronger collective voice against ZANU-PF during elections. A ZANU-PF district chairperson was more forthright about his party’s chances of winning the 2008 harmonised general elections. Predicting that ZANU-PF would face serious challenges at poll and possibly electoral defeat in the elections he quipped, “if the opposition leader fails to make it to the state house this time around then he should seriously consider quitting politics as he could never hope for more propitious conditions”.

In Maotsa, there was no change in the elected representative at ward level as the councillor was retained in elections having been first elected into Council in 1986. The councillor in November 2007 won the ruling party nomination for the 2008 elections

unopposed. There was an evident sense of continuity in community projects organized by the councillor in Maotsa. However, from 2000 the councillor faced increased competition from within his party and the opposition and his winning margins got narrower with each succeeding election.

The collective voice resulted in collaboration between different segments of the community. The community regarded teachers as fellow victims of failed government policies and collaborators in the struggle to restore normal service delivery. During interviews, at least six respondents argued that a further deterioration of educational services and closure of schools could persuade government to acknowledge the magnitude of the crisis and take steps to remedy the situation. They drew on the experiences of the 1970s liberation war when schools in rural areas ceased to operate and in a way sent a message to the then government that the crisis was deepening and the war unwinnable. Anticipating little prospects for change under the present government, the respondents were of the view that the rapid deterioration of services could result in enhanced collective voice, pressuring the government to either resign or face defeat in the next general elections scheduled for March 2008.

6.3.3 Broadening of the Civil Servant Asset Base

Under the weight of the collapsing economy and declining salary levels in real terms due to inflation, the rural salaried elites resorted to individual direct actions to broaden their asset bases in diverse ways. The most common asset-broadening strategy was to engage in income generating strategies. In a study in Zaka, southern Zimbabwe in mid 1980s, teachers were observed to be active participants in rural trade (Leys 1986, 267). The second strategy was for civil servants to seek redeployment to their home areas. Working near one's village enabled the civil servants to cut down on the huge transport bill, as they would live with their families. In Maotsa, three out of the five head of schools were local indigenes and at Mukwasi primary school, all the teachers were local. Equally important is that civil servants were increasingly engaged in communal agriculture. A majority of teachers and nurses became full time communal farmers. The perennial industrial actions also guaranteed the teachers time to tend to their farming enterprises.

Farming was a lucrative venture as a few with links to the bureaucracy managed to participate in the well-funded new farmer input support scheme. The civil servant farmers would typically use their relationships and status in the community to be included among the few farmers who got government provided farm inputs.

In Maotsa, the civil servants were initially excluded from the farm input schemes on the basis that they were salaried employees. However, they were later included and given preferential treatment after using collective pressure politics to lobby the chief who was also a teacher by profession. From 2004, teachers and nurses who were resettled farmers in Maotsa were guaranteed a share from the farmer input scheme. The Chief, who supported civil servants accessing cheap agricultural inputs, argued that they ought to get favourable treatment in accessing the inputs if they were to remain in the area that provided few other income-generating opportunities. As noted by Bratton and others (2005 96), civil servants being politically strategic constituency, use collective voice to benefit from ZANU-PF patronage.

A farmer participating in the agricultural inputs scheme would typically use only a small proportion of the inputs and offload the remainder of the inputs on the black market for high returns. In any event, it was far more profitable to trade the inputs than undertaking the actual farming. For example, a teacher-farmer got one tonne of fertilizer. He quickly offloaded less than 5 percent of the inputs to raise enough money to repay the full loan for the one tonne of fertiliser. Selling a further 10 percent gave a teacher-farmer an amount more than the state grain marketing utility would give them upon selling the harvest after the best of all farming conditions. The teacher-farmers, like other communal farmers sold their agricultural harvest on the shadow market, only remitting the minimal amount to the state grain company to ensure continued access to inputs. Future inputs could only be guaranteed by registering support through remitting part of the proceeds to the state grain company. In one transaction, the teacher-farmers (and other farmers) through collective voice actively sought to fully engage the state to access farm inputs as patronage benefits and disengage when marketing produce. This finding was consistent

with the observation by Chazan (1988, 134) that the state is often treated as “both oppressor and ally”.

6.4 Conclusion

The state implosion and subsequent decline in service delivery affected various segments of the community differently. The decline in education affected parents, teachers and responsible authorities differently. Reduced intergovernmental grant transfers challenged school authorities, as did inflationary increase in prices of inputs. There was increasing inability of parents to meet their fees and levies obligations, and high levels of teacher absenteeism and turnover. Parents struggled with increased costs of school materials and the need to raise contributions to compensate for the declining government inputs. Learners had to grapple with reduced professional support as teachers frequently downed tools in protest against poor working conditions and low salaries. The local leadership faced a challenge of reduced government contributions and ever-waning donor support.

The decline in central government support led to a shift in the contribution by government and communities. To cover the shortfall caused by the decrease in government grants, communities resorted to direct action and contributed more including payments of allowances to teachers whose salaries had been eroded by inflation. To evade government regulations regarding increases in school fees, parents coded the fees as donations and most of the externally sourced contributions were not reported to the authorities as was required by government policy.

Struggling under collapsing survival strategies some community members resorted to perverse coping mechanisms including withdrawing children from school. Equally prevalent was the perverse strategy of forced asset stripping. Yet some acquiesced hoping for a recovery in the near future.

The decline in public sector contributions resulted in limited access to the public health facilities to an increased reliance on donor support and higher costs of private care. Increasingly, the donor community played a crucial role in the direct delivery of primary

health care. The once vibrant village community workers network became non-functional and the home-based caregivers who were funded by donors increasingly undertook their role. Patients faced further obstacles of lack of transport when they attempted to access higher-level health facilities. The Maotsa clinic had access to external support and continued to provide basic services during the period under decline.

Civil servants diversified their assets through farming which provided lucrative returns through the abuse of the state funded agricultural input scheme. They used collective voice pressure politics strategies to access political patronage benefits.

University Of Cape Town

CHAPTER SEVEN: SHUMBA, EDUCATION AND HEALTH FINDINGS

7.0 Introduction

This Chapter presents and discusses findings on education and health from the Shumba area and is divided into three sections. The first section is on education, the second on health and the third on overarching issues. In Shumba, there are two primary schools and one secondary school. The local council administered the Tsatse primary school and Tsatse secondary schools. A Pentecostal Church had taken over the Mtanhaurwa primary school from the council in 2004. The two primary schools had been established during the colonial era whilst the secondary school was one of the many new secondary schools established by the Rural District Council with government aid in 1980. A council clinic serviced the Shumba community. Patients requiring specialist attention were referred to a District hospital.

7.1 Education

7.1.1 State Reliance to State Avoidance

This section traces the shift from reliance on government grants around 2000 to where schools actively avoided engagement with the state in 2007. In 2003, the Basic Education Assistance Module (BEAM) programme assisted twelve percent of primary and ten percent of secondary school learners (GoZ 2006, 6). Between 2004 and 2006, the BEAM programme was gradually rendered insignificant by the high rate of inflation. The national treasury allocated the BEAM grants based on fees levels approved for the previous year adjusted for inflation in line with the official Consumer Price Index (UNICEF 2008, 20). The central government projected fees rates that were invariably lower than the levels schools needed to operate in an inflationary environment. From 2004, schools had to effect regular increases in fees to cover the shortfall resulting from reduced central government grants.

At Mtanhaurwa primary school in 2007, the school opened the academic year with a fees structure of Z\$2000 per learner per term. In terms of their enrolments, the school was eligible for a BEAM grant transfer of Z\$72 000. However, when the funds were finally available for collection by the beginning of the second term, school fees had gone up to

Z\$15 000 per term per child and the cost of bus fare to and from the bank was Z\$200 000. In a bid to tame the rampant inflation, the central bank had imposed a daily cash withdrawal limit of Z\$5000 per account. Because of the high costs involved in accessing BEAM grants, the school did not bother to access that particular disbursement under BEAM that as a matter of policy did not cover any increases effected after budget approval at the beginning of each year. The schools were effectively avoiding accessing state benefits that exposed the beneficiaries to the effects of hyperinflation. The finding was consistent with the UNICEF review (2008, vii) which established that due to diminishing value and delayed payments of BEAM grants, some schools indicated frustration and lack of interest in the programme.

At Tsatse primary school in 2002, the BEAM grants were sufficient to cover the costs of fees for over one hundred learners but by 2007, the grant could cover only two learners having been eroded by inflation. The government deposited the BEAM grants into the schools bank accounts invariably late and usually two months into the term at the earliest. Due to an acute increase in poverty incidence, only a small proportion of those that qualified to benefit under BEAM were accommodated due to the declining annual allocations per school. The high demand for the diminishing grants led to social exclusion in some cases. In Shumba, children of single mothers were routinely excluded because they were supposed to benefit from their paternal home areas.

In 2007, the macroeconomic fundamentals had deteriorated because of the hyperinflation. The year began with a series of collective voice expressed as strikes by the teachers. There was an unprecedented shortage of essential teaching and learning materials such as books and when available, they were expensive. School fees were increasingly linked to the ever-appreciating United States dollar and the South African rand. The 'prices of goods were finding a natural link to the United States Dollar through the parallel market rate' (PRF 2003, 11). School fees were regularly increased, and often more than once per term.

The Tsatse primary school at the end of August 2007 invoiced pupils Z\$18000 for the forthcoming third term. However, upon opening the third term in early September the school demanded an additional Z\$300 000. Towards the end of that term during the last week of November, the school invoiced for yet another 'top up fee' of \$400 000 to complete the term.

Despite increased costs for stationery and the need for continual top ups of school fees, the richer parents, who were in the minority, took individual direct action to procure learning materials and stationery for their children. The pupils, especially those in classes taking public examinations at grade seven, ordinary and advanced levels, secured private textbooks. The teachers would however, require learners with privately procured texts to share them with other pupils as a way of increasing the student/textbook ratio. That arrangement resulted in richer pupils directly subsidising the poorer ones. For those in primary schools the private textbooks were kept at home for security, as they were purportedly lost at school. By end of 2007, the learner/textbook ratio was most favourable at Mtanhaurwa primary school with a ratio of 2:1 for the main subjects of English, Mathematics and Shona.

Following application of collective voice pressure politics to education authorities, Tsatse secondary school attained advanced level status and classes commenced in 2005. The computer science block was converted into an advanced level classroom. There was also a shortage of the required textbooks at all the levels. Tsatse secondary school did not offer science subjects at an advanced level due to a lack of equipment and qualified teachers. Only Tsatse primary school had managed to construct classrooms for grade zero. The construction of grade zero classrooms stalled at roof level despite the school receiving support from donors.

7.1.2 Direct Action

The contributions by the community compensated for the decline in financial support from government. In all schools in Shumba, the pupils were responsible for supplying their own stationery and textbooks. The Zimbabwe schools examination council

(ZIMSEC) from 2004 failed to supply the requisite stationery and required candidates to supply their own stationery, further shifting the costs to the learner. All schools in Shumba required pupils to procure stationery independently. The parents in Shumba found it cheaper to procure stationery independently as they were nearer the metropolitan capital which they frequently visited to market farm produce.

The macroeconomic decline brought about new forms of criminal activities in Shumba. The previous nuisance of minor thefts from schools turned into a major crisis as schools were stripped of electrical fittings, padlocks, textbooks and virtually anything of value. The stolen items had a ready market in the informal sector in the capital Harare. The theft of electricity cables and transformer oil disrupted electricity services. In September 2006, there were three consecutive reported cases of the theft of cooling oil from a step-down transformer on the national electricity grid in Shumba community, two at a shopping centre and one at a school. The national energy company, the Zimbabwe Electricity Supply Authority (ZESA) threatened to withdraw the transformer if the community failed to safeguard the infrastructure. If the electricity services were withdrawn under those circumstances, the community would be required to reapply for a service, a process that took up to five years for services to be restored.

In a bid to preserve the service, the community mobilized resources and hired local personnel to guard the transformers overnight. Since the transformer was located in the schoolyard, the guard had an expanded mandate to guard the whole school premises. The guard was armed with a rifle and his salary was wholly financed by the community. The energy utility's inability to provide security and threats of service withdrawal foreclosed the application of voice. Exit was also not possible as the energy company enjoyed statutory monopoly over the generation and distribution of grid power throughout Zimbabwe. The only viable option was to collectively act and directly produce the public good, security. Transcending theoretical expectations where consumers complained, the service provider instead used power of monopoly to demand direct action by the community

The teachers and businesses who relied on the electricity service took an active interest in organising the community for the communal direct action. The other school in Shumba, Mtanhaurwa primary school, had been the first in 2005 to engage an armed guard paid for by parents when they experienced a series of theft of textbooks and other materials from the school. The community relied less on state law-enforcement agencies and suspected thieves apprehended by community members were routinely tried before the traditional courts and occasionally, some unrepentant 'convicts' were handed over to the Zimbabwe Republic Police. The appointment of the security staff by the community was a long-term expenditure obligation requiring continual contributions, commitment and organisation by the community. The phenomenon of community contributing toward public services was also observed in rural Kenya when communities in response to the failing state and decline in services, recruited teachers to augment the inadequate number of government paid staff (Francis and Amuyunzu-Nyamongo 2005, 19).

Efforts at communal direct action were not always successful. Initiatives at Tsatse secondary school to levy for the purchase of a school vehicle in 2002 failed due to alleged fraudulent actions by the members of the school development committee. The community withdrew the contributions for the school vehicle following the allegations of misappropriation of funds. Efforts to provide local security inadvertently led to an increase in cases of vigilantism. Two young men suspected of having stolen cooling oil from an electricity transformer in Shumba were in September 2006 tortured by the 'youths' and only released to the police after they had 'confessed' to the crime.

7.1.3 Exit

In response to a decline in the quality of educational services, the parents withdrew learners from poorly performing schools and enrolled them in schools perceived to be offering better services. There was an exodus of pupils from Mtanhaurwa primary school to Tsatse primary school when Mtanhaurwa primary school was threatened with closure due to inadequate infrastructure between 2001 and 2003. Traditionally, Mtanhaurwa primary school charged lower fees than Tsatse primary school but the threat of closure because of collapsing infrastructure forced the school to increase the fees significantly to

meet the demands for reconstruction and maintenance. Faced with a higher bill for a poorer service, parents initiated transfer of learners from Mtanhaurwa to Tsatse primary school. Because of the transfers, enrolments at Tsatse primary school rose from 720 to more than 800 between 2002 and 2004. Tsatse primary school had two classes for each grade and a ‘hot seating’³⁴ system where some classes came in the morning and some in the afternoon as there was insufficient classroom space and equipment.

The internal provider exit was not available to all members of the community as it was inaccessible as an option for the poor majority. This was because it was too expensive for the poor parents as it entailed acquiring a new set of school uniforms and registration fees at the new school. The community devised strategies for controlling the influx of pupils from poorly resourced to better resourced and relatively better performing schools. Access to school was controlled by charging a variety of entry fees to new pupils. Two schools in Shumba, Tsatse secondary school and Tsatse primary school, charged new recruits a non-refundable (*makandinzwani*) registration fee *in lieu* of foregone contributions. The registration fee was a mechanism of solving the fee rider problems and preventing influxes of more learners than the system could accommodate. The registration fees were substantially higher than the annual school fees. Payment of the registration fee was a precondition to secure a place at the school. The registration fee was a hindrance to the very poor who could not afford it thereby foreclosing the exit option.

The poor parents ‘locked’ into the poor performing schools had no viable exit option and resorted to voice to register discontent over the decline in the public services. The difficulty of exercising the exit option spurred the development of collective voice among community members. The wider involvement of community members resulted in the school accessing external support.

³⁴ Hot seating is the characterisation of a situation at schools where due to inadequate classroom space, two classes share one classroom with one class coming early in the morning and ending towards noon and another starting just before noon and ending late in the afternoon. The classroom seats literally remain ‘hot’ the whole day hence the term ‘hot seating’.

In Shumba, pupils transferred from Tsatse secondary school to Parirewa high school located outside Shumba ward. Parirewa high school had run advanced level classes for longer period and consistently produced better results than most schools in its cluster. Some parents did not want their children to be trailblazers for advanced level classes hence the reluctance to send children to the Tsatse secondary school that had only recently gained advanced level status. In order to attend more distant schools, older pupils in secondary school stayed with relatives or sought paid private lodgings from the villages near the schools they would be attending. This finding was similar to observations by the Presidential Commission on education and training of the 'existence of illegal bush boarding settlements' in Mashonaland Central province in the late 1990s³⁵ (Nziramasanga 1999, 45).

In Shumba, a local indigene who was head of a private boarding school in a neighbouring district facilitated public internal exit by placing learners from the area at his school. Loyalty to one's religion influenced the choice of schools with members of particular conversions preferring to send their children to schools administered by their own denominations.

Some parents also sent their children to stay with relatives or spouses in urban centres where the education facilities were perceived to be better. The option was available to the wealthier families who had at least one spouse in in/formal employment in the urban area and maintained a rural home. The strategy of moving children to urban areas for education purposes was prevalent in the early years of the crisis until 2004. An earlier study on the impact of ESAP on Zimbabwean communities (Mwanza 1999) noted this form of exit with learner movement from rural to urban areas.

7.1.4 Teacher Based Strategies

All teachers in the surveyed schools were involved in some form of trading and those not involved in the cross-border trade bought local products, such as grain and vegetables for resale in the city and brought goods such as sugar, cooking oil, exercise books and pens

³⁵ The Nziramasanga Presidential Commission on Education and Training (1999, 45) termed the bush boarding schools, "appalling children squatter camps".

from the city for resale in the rural areas. Teachers also grew crops for own consumption and commercial purposes. In Shumba, teachers had vegetable gardens and a few worked on them on a commercial scale. The community in Shumba was against the teachers growing the vegetables on a commercial scale, as they feared it tended to distract educators from their core mandate of teaching. However, the parents detested the competition from the teachers turned vegetable farmers who in some cases used free reticulated water, reducing their input costs. The community tolerated petty trading of grocery and stationery items by the teachers but raised concerns when the trading became commercial and impinged on their teaching duties. The internal public exit strategies of generating income outside formal employment by teachers enabled them to participate in the informal sector and continue to offer basic educational services.

Faced with a collapsing education system and insignificant support from central government, the teachers also adopted classroom based individual coping strategies. A small proportion of the parents could not supply the required number of exercise books on time. In that event, the teachers in cooperation with the SDC changed the rules. The teachers allowed the poor learners to use one exercise book for more than one subject. However, the solution provided only temporary relief, as learners would require exercise books at more regular intervals as they filled quickly. In some very desperate situations, teachers permitted pupils to use scrap paper for exercises and assignments. The problem with the use of scrap paper was that the learner could not collate the loose sheets for further reference and study. In 2007, a third grade class at Tsatse primary school recorded the most desperate in-class coping strategy adopted in response to shortage of stationery. The learner in that class had to use the classroom floor as chalkboard to do daily exercises. Since chalk was also scarce, the learner used charcoal.

In 2007, schools in Shumba experienced severe shortages of examination material. For the end of term examinations at Tsatse secondary school and Tsatse primary school, the teachers had to write the tests on the chalkboard, a laborious task given the limited number of chalkboards. Teachers were improvising to offer a service that neither the government nor community could provide. The efforts of the teachers in this regard had

only partial success as diagrams for technical subjects at secondary level that were difficult to represent on chalkboard were simply left out. When the end of year internal controlled examinations were compromised, it became evidence of the failure of the system to deliver and prompted teachers and parents to jointly search for a solution. In some cases, it was an opportunity to strategise to access external resources and deal with perceived 'free riders'. The challenge was that there were very few free riders as most parents in arrears were in that situation not because they preferred to shirk but because of extreme deprivation.

7.1.5 Leveraging External Support

To meet the shortfall created by reduced government contributions, the community and individuals leveraged external resources in order to provide the services directly. External donors were of four types: individuals, corporate, churches, and international aid organisations. Individuals who provided support were based mostly in the diaspora but occasionally lived locally. The faith-based organisations also played a significant role in the provision of education services. In Shumba, when the Rural District Council that was responsible for the three schools was in 2000 unable to provide any grants to the schools, the community responded by adopting a variety of strategies which reflected the requirements at each school. At Mtanhaurwa primary school, the school infrastructure had become dilapidated and in 2003, the Ministry of Health and Child Welfare inspectors delivered a final warning to close down the school or make the necessary repairs. The state of the school infrastructure posed danger to the safety of both learners and teachers. The classrooms and the teachers' houses were derelict and there were no adequate ablution facilities.

The community discounted council assistance because of its previous poor record. Aware of their inability to mobilise the required resources, they sought the assistance of donors. Among the potential donors were the Salvation Army Church that had originally built the school and a Pentecostal Church that was making inroads in the area. Both churches showed interest in taking over the school. Whilst the Salvation Army did not have ready resources, the Pentecostal Church claimed to have the capacity to reconstruct the school

infrastructure immediately. The community negotiated with the church for the reconstruction of the infrastructure at the school. The Pentecostal church agreed to provide building materials and skilled labour while the community provided local inputs such as river sand, pit sand, water, and unskilled labour. The community organised itself into village networks with groups taking turns to provide the required services. The community organised their contributions through village networks with groups taking turns to provide the required labour. The church committed to complete the construction of all classrooms in a year and to upgrade the school to a boarding secondary school within a decade.

The donation by the Pentecostal church was conditional on the church becoming the responsible authority and the renaming of the school after the founder and head of the church. The Pentecostal church became the responsible authority for Mtanhaurwa primary school from 2004. The RDC that was the responsible authority for the school welcomed the takeover. Indeed, the local authority was eager to divest the school to minimize obligations to communities. The ward councillor for the area indicated that the church takeover of the school was in the best interests of the community as the council was 'for all intents and purposes, financially bankrupt'. Council was unable to maintain infrastructure at the other two schools and the only clinic in the area. In contrast, some infrastructural development became evident at Mtanhaurwa primary school soon after the takeover by the church. In 2007, four years after the church took over; the building of classrooms and teachers houses was more than fifty percent complete. Progress on the construction project was a remarkable achievement given the then prevailing adverse macro environment characterised by shortages of building materials and cash. Four classroom blocks had been completed. Each block had two classrooms and two offices (see plate 2 for pictures of developments at the schools).

In mid 2006, after noticing slower than anticipated progress of the reconstruction project, the community negotiated that the original verbal agreement between the church and the community be put in writing. The community was employing collective voice pressure politics to exact external contributions. By the end of 2007, some members of the

community were indicating that the church was in breach of its contract as it had failed to deliver all the classrooms in the time specified in the original agreement. To the calculating community it was sufficient grounds to reclaim ownership of the school. When the church had taken over, they had committed to deliver all sixteen classrooms in one year.

The village head, after whom the school had been named, demonstrated particular interest to have the transfer of school to the church reversed. He attempted to apply individual voice by enlisting the support of the local Member of Parliament and the Governor and Resident Minister for the province to effect the reversal of change of name. The conflicts between the local churches presented propitious conditions for the community to address subterranean concerns of ownership and control of the school.

The transfer of the school from council to the Pentecostal church was to cause some acrimony between the Salvation Army Church and the Pentecostal church. When the Salvation Army had originally built the school, they had also put up the church building within the school premises. After the takeover in 2004, the Pentecostal church in 2006 demanded that the Salvation Army Church relocate from the school premises. The Pentecostal church also suggested that all staff members at the school be practicing members of its church. The teachers resisted the proposal to join the Pentecostal church and indeed offered to resign *en-masse* instead. The Salvation Army Church resisted the eviction and made a counter claim that as original owners they should have exercised the right of first refusal to take over the school from the council.

Members of the community took sides in the conflict based upon their religious affiliations. The community leadership waited ready to take advantage of the conflict to regain control of the school. One proposed solution to the dispute between the two churches was to return the school to the community. The community efforts towards repossession of school stalled because the reconstruction at the school was still under way. In an interview, a headman who had been a member of the SDC that negotiated the transfer of ownership summed up the strategy, “the school remains the property of the

community, the current arrangement with the Pentecostal church is only meant to facilitate access to assistance to rebuild the infrastructure. In due course the community will regain full control of the school”.

After the takeover by the church, the school had better classrooms but still had no stationery and furniture. For access to stationery and furniture, the community approached a former pupil based in the United States who from 2005 began supplying the bulk of the school stationery and textbooks requirements. The individual donor supplied all the stationery for teachers and basic stationery for all learners identified as vulnerable and bought basic texts for each class. The same donor was also sponsoring the electrification of the school. Despite reduced government support, the school that had been threatened with closure was four years later steadily improving due to the infusion of support from multiple donor sources and contributions by the community. The developments were despite the adverse macroeconomic and political environment.

Local residents also provided significant assistance as individual donors. In Pasipamire village, a local businessperson sponsored six vulnerable children from the village although he had no kinship relationship with them. The businessperson provided bursaries to cover the costs of school uniforms, fees and the requisite stationery. Of note was that the benefactor preferred to remain anonymous. Two families also catered for school-going orphans who were not kin relations.

The community also leveraged support from individuals who were foreigners. Two schools in Shumba, Tsatse secondary school and Tsatse primary school had since 1995 attracted the grants from an individual donor. The donor had taught at the school as an expatriate in the 1980s and had kept contact with the community after returning to his native Australia. Through his fundraising efforts overseas, the school had managed to build and equip a modern day library. To the credit of the donor, the school had been linked to another donor from Europe who built a computer centre and equipped it with computers. The school then began to offer computer science as one of the electives, a rare feat in the rural areas. Through the European based donor, the school had also drilled a

borehole and both primary and secondary school teachers' houses were supplied with reticulated tap water. However, the post-2000 developments in Zimbabwe seemed to have stopped the donor momentum and the latest request for the donor to assist in repairing the borehole pump sent out in March 2007 still had to be acknowledged nine months later. The school had been invoiced Z\$220 million for the repairs of boreholes against an average fee of Z\$30 000 per head for the over 1200 pupils.

International aid organisations were a significant source of material support in the education sector. To fill the gap by the declining state support in 2005 the Shumba community had enticed the services of donors, Christian Care International and Mercy Corps, to operate in that area under a three-year renewable programme. Mercy Corps provided support to orphans and other vulnerable children. The donor introduced some innovative strategy for extending aid. The aid organisation provided a school with an 'untied' block grant. From that block grant, the school worked out the number of students to benefit from the amount at prevailing fees rate each year. The block grant was then used for major capital developments such as purchasing building materials before it was eroded by inflation. In terms of the agreement between the school and the donor, the students benefiting from the block grant were exempted from payment of top up fees in the event of inflation-based adjustments in charges.

In 2006, Tsatse primary school received the first block grant from Mercy Corps and used it to construct a grade zero classroom. Mercy Corps also offered targeted support for uniforms and stationery. However, due to hyperinflation, the allocations for uniforms and stationery were inadequate to meet the needs of the community. In 2007, Mercy Corps gave each targeted pupil at primary level three exercise books against the minimum requirement of six exercise books. The Mercy Corps project was scheduled to end in December 2007. The community requested agricultural inputs from Mercy Corps to undertake a community agricultural project to feed the vulnerable orphans. The case raised the critical issue of sustainability of donor-financed initiatives after the withdrawal of external support.

Communities also accessed support from indigenous corporations. One of the local banks created a 'window' to sponsor a group of indigenous businesses in Shumba on condition that the businesses in turn reinvested 10 percent of their profits into community projects. When the scheme was first implemented in 2003, the money transferred to schools by the businesses was significant. By 2006, the high inflation had eroded the contributions by the local corporate. However, occasionally the local businesspeople donated to schools by providing costs for sporting and other school competitions. The Shumba community was successful at leveraging various types of external support in order to produce the public goods in place of declining provision by central government.

7.1.6 Political Patronage

In addition to donor support, communities engaged ZANU-PF politicians with interest in the area to access government allocations and public enterprise services. In Shumba, the community relied on the local Member of Parliament who was a former central government minister to access resources from government ministries and local non-governmental organisations. The community leadership had discovered that the MP, a former minister recently demoted from government following the 2005 general elections was then readily available for constituency matters. The Member of Parliament's introductions and recommendations to the provincial offices of the Ministry of Rural Housing and Social Amenities mandated to build rural infrastructure resulted in a firm commitment to supply Tsatse primary school with roofing material for grade zero classrooms.

7.1.7 Voice

In few instances, the communities also resorted to mild forms of protest as a way of persuading authorities to reverse the declining trends in service delivery. All schools in the rural areas pay an annual land lease fee to the council irrespective of who the responsible authority is. Council owned schools were also required to pay the annual land lease fee to the local authority. When council failed to provide any services to the school the community leaders in Shumba in 2002 negotiated with council for a waiver of the land lease fees. The schools had also ceased submitting schools fees to council as these were administered at school level by the SDC. One respondent who was in the SDC for

Tsatse secondary school from 1998 to 2005, indicated that the refusal to hand over the land lease fee to the local authority was a strategy of minimising expenditure and exposure to poor and inefficient management by the council. From that time, the community negotiated their way out of lease fees they effectively ceased regarding council as a senior partner in the provision of education and hence had to forge new partnerships with external donors. The withholding of the lease fee brought financial relief to communities but also ultimately contributed to the financial bankruptcy of the local authority.

At Mtanhaurwa primary school in 2006, the parents protested to the head against a teacher who was habitually absent on sick leave and when at school always had in stock of goods commonly procured from South Africa or Botswana for sale. After the protest, the teacher successfully sought and got transfer to the capital, Harare. The community recounted the event of the teacher forced to seek transfer with pride and a sense of victory in the successful application of collective voice pressure politics.

7.1.8 Helplessness and Apathy

In some instances, communities and individuals were not successful in generating viable response strategies and ended up adopting individual responses that were perverse and detrimental to their immediate and long-term welfare. When faced with increased costs of education one perverse individual response was simply withdrawing children from school guided by a matrix of gender and age. Girls were more likely to drop out earlier from school than boys. Girls were also better placed to get employment as house cleaners in the urban areas as opposed to agricultural related and less rewarding work available for the boys. In an FGD in Shumba with 'out of school' girls aged between sixteen years and twenty-three, six out of the eight girls indicated that they had been withdrawn from school to free scarce resources for their male siblings. The decision to withdraw a child from school was partially informed by the patriarchal structure of the Shona society that regarded the role of the girl child in a family as transient whilst boys were inheritors of their family estates and custodians of clan identity. Dropping out of school also got

impetus from the diminishing value of education as reflected in high unemployment rates among high school graduates.

The high inflation and unemployment rates reduced the economic returns on investments in education. The prevalence of university graduates earning well below the Poverty Datum Line acted as a disincentive for the youth who then generally opted for informal jobs requiring little education, but giving relatively high returns. Chaitemura, a 28 year man engaged in brokerage of livestock, a trade requiring little or no formal education but yielding high returns then, jokingly but succinctly summed it “*dai ndakafunda ndiri rombe*”, (had I been successful in school, I would have been exposed to poverty). This sentiment demonstrates the predominance of survival over the prestige of investing in education.

In Shumba, there was a case of Muchauraya, a 35-year-old father of four. He sold most of his assets to raise money for the treatment of his mother-in-law who fell ill in 2005. Muchauraya's wife had to nurse her mother and that entailed relocating from her matrimonial home. Muchauraya made constant trips between his home and that of his in-laws. He failed to raise the money required for ‘top up’ for his daughter in grade seven. The daughter could not qualify for any external assistance, as both parents were still alive. Muchauraya chose to withdraw the daughter from school. Initially the withdrawal was planned to be temporary and Muchauraya hoped to have the girl back in school by 2008. However, the odds were stacked against the daughter who had secured a job as a house cleaner in Harare and was contributing substantially to the desperately needed rebuilding of family assets.

Another common trend was that when pupils ‘temporarily’ dropped out of school due to problems of lack resources they would be hard-pressed to find employment. When and if they got employed, the children left home and disappeared in the ‘adult’ world of work where they became ‘invisible’ and hence ineligible to be considered for assistance to return to school. In Shumba, a missionary operating in the area offered a scholarship programme targeted at children out of school who failed to qualify for assistance under

any other programme. In 2007, seven pupils from the Shumba community benefited from that scholarship programme, an insignificant number given the large numbers in need.

One challenge posed by the shortage of stationery was the end of term examinations. Examinations would normally be held at the end of the term when the schools would have used up their incomes and the parents exhausted from several 'top ups' called for during the term. In that event, the ability and willingness of poor parents to pay any extra charge two weeks before schools closure was reduced. As a means of enticing contributions, pupils were sent away before the examination forcing most parents to pay. A few poor guardians and parents failed to meet such demands. To minimise embarrassment resulting from sending learners back to school without the required fees, learners remained at home and waited to rejoin the school in the following term. Such learners missed the end of term examinations. The automatic promotion system through grades at the primary and lower secondary levels enabled learners without previous grade results to proceed to the next grade.

7.2 Health

Findings on health from Shumba are discussed in this section. The decline in health services provision attracted diverse response options ranging from local direct action, leveraging external assistance, use of alternative medicine and self-medication among other strategies.

In Shumba, the health facilities were grossly inadequate. The clinic was a mere three-roomed structure. The structure had been a dairy milk collection centre that had been converted into a clinic in 1967. Despite increases in the population size and the higher demand for health services from 1967, the structure had remained unchanged. There was a severe shortage of working space. The clinic had one patient bed. In instances where an expectant mother had to deliver during outpatients consulting hours, it invariably resulted in a crisis as the treatment room doubled up as the maternity ward. The second room was the reception and consulting room whilst the third room was the dispensary. The clinic in Shumba had no piped water and the nearest water source was a borehole fitted with a

manually operated 'bush pump' (plate 2 has photographs showing water source). The Shumba clinic had no landline telephone, as it had never been installed.

7.2.1 Collapse of the Primary Health Delivery System 2000-7

One of the cornerstones of the primary health system in Zimbabwe, the village community workers (VCWs), were severely compromised. In Shumba, out of the seven VCW trained in the early 1980s, only one remained active. Three died while three resettled outside the ward area under the government sponsored Fast Track Land Reform Programme that commenced in 2000. The only active VCW in Shumba was also the ZANU-PF district chairperson. It was apparent that having continual accesses to the community as a community worker aided his political career. There was synergy between his individual political interests and collective public health concerns.

There was a shortage of medical staff at the council clinic in Shumba. Out of an establishment of four nursing positions, a maximum of two had been filled at any time since 2003. By August 2007, the district referral hospital had been without a doctor for eighteen consecutive months. Since 2000, the referral hospital in Shumba had not had more than two doctors out of the approved establishment of four. The 120-bed referral hospital for Shumba from 2004 to 2007 operated at an average capacity of 30% bed occupancy as it had no doctor and was often short of basic medicines.

The clinic occasionally received sundries such as soap, candles, bandages and cleaning materials from the Rural District Council that owned and administered the clinic. Besides staff shortages, the Shumba clinic also experienced acute shortage of medicinal drugs and equipment. In Shumba, medical professionals narrated the pain and anguish of watching helplessly as patients died of treatable ailments like diarrhoea. There was also some re-emergence of previously conquered diseases such as scabies, bilharzia and rabies. Malaria was surfacing in the area previously free of the disease. There was no official clinic transport for transferring patients in need of specialist attention. Patients referred to hospital had to use public transport but occasionally walked the eighteen kilometre journey.

The referral district hospital operated an ambulance that was used to transport patients to the main teaching hospital in Harare. Since the referral hospital sometimes had no doctors in post, patients requiring the attention of a medical doctor were further referred to the next referral centre that was one of the level four teaching hospitals in Harare. However, from 2006, the district hospital also faced problems of shortage of fuel for its ambulances. Most patients requiring specialist services had to find their own means and way to the main referral hospital in Harare.

In Shumba, the HIV and AIDS patients were referred to the district hospital for voluntary counselling and testing (VCT). By October 2007, the opportunistic infections programme at Shumba clinic had 51 patients, 11 in stages one and two and 40 in stages three and four³⁶. Of the forty in stages three and four, only three were already on ART and of the 37 who needed CD4 count only two had managed to pay the costs at Z\$250 000 per patient. If the CD4 count was less than 200 then the patient was required to pay for the liver function test that cost Z\$1.2 million. In August 2007, the two patients who had undergone CD4 count could not afford the required liver function test and by October 2007 had still not taken the test. Three people receiving ART but patronising the clinic for opportunistic infections had transferred from urban areas and one patient had transferred from the private scheme that was becoming increasingly expensive. The three patients still had to go to the District hospital for re-supply of antiretroviral medicines and regular checkups.

The active element of AIDS management at Shumba clinic was the cotrimoxazole prophylaxis and antiretroviral prophylaxis for prevention of parent to child transmission (PPTCT). The clinic administered nevirapine in cases of HIV positive mothers as a central feature of PPTCT. The use of nevirapine in PPTCT began in 2000 (PRF 2003, 140). In Shumba, the patients on cotrimoxazole prophylaxis often could not get the

³⁶ WHO recommended stages in HIV and Aids management CD4 count strata; less than 200/uL, Art recommended. High risk for the development of OI and prophylaxis against pneumocystis carinii is indicated; 200 to 350/uL-Art recommended, it is suggested to have at least two consecutive low CD4 count within an interval of twelve to fourteen weeks before starting ART; more than 350/uL, ART deferred.

antibiotics when out of stock at the clinic. They were then required to procure the antibiotics using their own resources and some could not afford it leading to default and consequent increase in cases and severity of opportunistic infections.

Though ARVs were free at the point of consumption under the Government programme, the access costs were prohibitively high. In Shumba, the referral hospital in 2007 only had VCT services and could not initiate ART as they did not have a doctor in which case all patients requiring ART were referred to the main teaching hospital in the capital.

In Shumba, the HIV positive condition was stigmatised and still whispered as the ‘killer disease’. The Zimbabwe Human Development Report (2003, 85) noted that stigmatisation of HIV was still rampant with victims, being “subject of verbal and non verbal running commentaries” in communities. A 2004 survey of public opinions established that between 1999 and 2004, the social stigma of HIV and AIDS pandemic was deepening with more respondents in a survey refusing to answer directly questions about the pandemic (Bratton, Chikwana and Sithole 2005, 87). Recognising resource limitations, the Ministry of Health and Child Welfare responded to the AIDS challenge by encouraging community and home based care for patients who could not be accommodated in hospitals (PRF 2003, 125).

7.2.2 Local Communal Direct Action

In Shumba, the clinic had been established as a first aid centre and as more services were offered, the infrastructure gradually became inadequate for the needs of the community. The local council that operated the clinic perennially failed to allocate funds for upgrading the clinic infrastructure. The community responded to the challenge by organising themselves through the local government structure of councillor and headman to contribute directly towards upgrading the clinic.

Between 2000 and 2001, the community mobilized itself and provided bricks for upgrading the clinic hoping to get assistance from council. The community got a donation of roofing material from a neighbouring white commercial farmer for the erection of a

shed to be used as a reception area at the clinic. The commercial farmer contributed because his workers received treatment at the clinic. Upon approaching the local authority with the request for assistance with cement, the community was advised that there was no allocation for the project factored in the council budget. At that point, the Rural District Council also insisted that all infrastructural developments at the clinic ought to be undertaken as per layout plan to be produced by council. The community was eager to have the approval of council before embarking on any developments. The Operation *Murambatsvina* (Restore Order) was poignant and instructive of government's willingness to punish transgressors of development control regulations³⁷. The community had intended to put up a basic functional structure in the form of a veranda shed and had not anticipated hindrances from the local government. The community remained loyal and complied with the dictates of council as regards requirements for a building plan though they regarded such conditions as being unreasonable. The basic argument by members of the community was that disregarding council directions could be tantamount to disobeying lawful orders of the ruling party and central government. In this instance collective voice pressure politics did not only fail to yield a positive outcome but worked against local communal direct action initiatives to deal with public services deficits.

After writing off council as a partner in the development of the clinic, the community resolved to retrieve the plan from the local authority and take over the clinic upgrading as a community funded and managed project³⁸. At a community meeting called by the local councillor on 23 August 2007, it was reported that the plan for the layout plan for the clinic had been retrieved from council. There was a sense of empowerment and jubilation in acquiring the layout plan and the community taking charge of the building process. The community meeting resolved that each family would contribute Z\$100 000 towards the cost of cement and each of the twenty-two villages would contribute 3000 bricks for the construction of the clinic. The community recognized that their own contributions were far short of total amounts required to complete the upgrading. They reasoned that it

³⁷ The central government initiated Operation Murambatsvina/Restore Order began on 19 May 2005, with no warning. The operation entailed the clean up of all major urban centres and growth points in the country by way of demolishing all illegally built structures (Tibaijuka 2005).

³⁸ The researcher attended the community meeting held on 23 August 2007 at Shumba Business Centre.

would be easier to attract donor support to complete an ongoing project than for starting a new one. The roles of traditional leadership in mobilising community efforts were acknowledged. Respondents indicated that the leadership in the community and at the clinic over the years had failed when required to lead in mobilising resources for improvement of the infrastructure at the clinic. The respondents contrasted the low performance of the current headman with that of his predecessor who between 1982 and 1985 mobilised the community to contribute towards the construction of a community hall.

The Shumba community encountered the “free rider” problem regarding contributions towards upgrading the clinic as by December 2007 no contributions had been made as per August 2007 resolution. All the respondents were prepared to contribute on condition that they could trust the leadership to be honest and to have the political will to ensure that other members contributed their dues. Perception among respondents was that the local leadership was corrupt as the councillors were routinely voted out for allegedly embezzling contributions. The community recounted with bitterness how the leadership had embezzled the \$7 per family contributions made in late 1989 and early 1990 for upgrading the same clinic. Failure of previous communal direct action efforts therefore adversely affected contemporary efforts at community action. The incidence led to dismissal of the committee but no money was recovered and the matter was not reported to the police.

7.2.3 Leveraging External Support and the Erosion of State Influence

The community actively sought external support to compensate for the decline in central and local government support. The Shumba clinic accessed external support from individual donors. The local leadership in Shumba had enticed an individual donor who had funded a water project at the local school to fund the reticulated water project for the clinic. Though the borehole had been drilled, the project stalled as the donor failed to procure pressure pumps from the local market. In Shumba, Christian Care provided the home based caregivers (HBC) with first aid medical kits.

The community also took advantage of all possible sources of external support. In Shumba, the researcher witnessed a case where the community took advantage of the University of Zimbabwe (UZ) Medical School, Physiology Department research project in the area. The Department was researching the occurrence and prevalence of non-communicable diseases in the area. However, over and above the research project priorities, the participants consulted medical practitioners in the research team on a variety of other matters such as problematic old fractures and other ailments, communicable and not.

The community also exploited the ZANU-PF patronage system to access external resources. Through collective voice pressure politics, the community had unsuccessfully petitioned the Provincial Governor and Resident Minister and the local Member of Parliament for assistance in the construction of the clinic. The community however remained optimistic of the efficacy of the collective voice.

When faced with a shortage of essential drugs, the clinic in Shumba survived by borrowing and exchanging the medicines with other rural health centres. The medicines mostly exchanged were essential antibiotics. In Shumba, the exchange of medicines was limited to a circuit of three local authority clinics.

7.2.4 Reordering of Health Service Provision

In Shumba, the nurse in charge at the rural health centre was applauded by the community members for routinely attending to maternity cases that were in terms of the Ministry of Health and Child Welfare guidelines previously referred to the district hospital. When the doctor at the district hospital could no longer make his monthly outreaches to clinics due to shortage of fuel, more women gave birth at home, as they could not afford the costs of transfer to the district hospital. In 2005, the Medical Officer at the referral district hospital directed that the chief nursing officer at Shumba clinic would assess the condition of the expectant mothers and facilitate delivery if there were no complications anticipated. The clinic referred the patient to the district hospital only when they anticipated complications during delivery. That arrangement was unknown to

and in contravention of the Ministry of Health and Child Welfare guidelines because the clinic lacked basic facilities such as running water. Because of an informal collaboration between two levels of service providers, a service was extended to people who would otherwise have gone without.

The nurse at Shumba was also respected for his individual actions particularly the visits to the villages with daily doses of injectible antibiotics for the bedridden patients. This was a function to be performed by the home based caregivers in mild cases or the referral hospital in acute cases. The Zimbabwe Human Development Report (2003,101) also noted that nurses at district hospitals were required to perform duties outside their mandates, for example, administering intravenous fluids, a function meant to be performed by a medical doctor.

7.2.5 Internal Provider and Public Exit

In Shumba, patients dissatisfied with the service provided by the local council clinic resorted to internal public exit and sought services at the Catholic Saint Josephs mission hospital 28 kilometres from Shumba clinic. The relatively better-stocked Roman Catholic clinic provided a free service to senior citizens and generous payment exemptions to the indigent. When extended periods of hospitalisation were anticipated some poor patients from Shumba travelled about 200 kilometres to Karanda mission hospital in the neighbouring Mashonaland Central province and more than 150 kilometres to Mutoko hospital in the eastern Mashonaland East province for a perceived better and cheaper service. Karanda mission hospital and Mutoko district hospital were designated antiretroviral sites (National Aids Council 2009) and hence some of the illness referred there could have been HIV related.

The rural elites comprising of businesspersons, civil servants, non-governmental organisation workers and pensioners, 'voted with their purses' and accessed private surgeries in the city for a swifter service. The powerful rural elite from the non-poor category continued to access private health facilities. In Shumba, because private health facilities could be easily accessed in Harare, there developed tension between private

interests and collective interests. Gaining access to private services resulted in the salaried elite disengaging from community decision-making on improvement of service, in a way denying the community an active voice. In Shumba, ordinary farmers accessed City of Harare health facilities and private care when they visited the city to market farm produces. Easy availability of the exit option in this instance worked against the prospects of effective local collective action. However, the private facilities were not accessible to all members, with the more powerful members of the household likely to access them more than others.

Heads of household had unfettered access to family income. In Shumba, a septuagenarian man was able to use private health facilities in Harare where he had gone to sell the family crop of tomatoes. A recurring dental condition worsened as the old man was exposed to cold weather conditions in the open space where he slept in the city in readiness for the market that opened around 0330 hours. After selling the crop, he promptly went to the nearby City of Harare dental care centre where he had a tooth extraction. He admitted that not all family members could exercise the same latitude with family income in the manner he did.

The second type of exit was the internal provider exit when patients patronized similar public services offered by public health institutions but perceived to be a better service or any service at all. Upon failing to get medicines at the local clinic, villagers in the northern boundary 'voted with their feet' and travelled between 15 kilometres and 20 kilometres to the rural health centre operated by the Ministry of Health and Child Welfare in the neighbouring northern Mashonaland Central province. The rural health service centre offered free services including drugs when they had them in stock.

Some villagers located on the eastern border of the ward took advantage of the mobile clinic offered by a seed company to its employees. The seed company provided prenatal, postnatal and child immunisation services in conjunction with the Ministry of Health and Child Welfare. The company provided transport and allowances for health personnel whilst the Ministry of Health and Child Welfare supplied the medicines. The service

though targeted at farm employees was accessible to members of the neighbouring communal areas.

Occasionally, the residents of Shumba would go to the teaching hospital in Harare for treatment. The teaching hospital being a level-four referral institution had a relatively well-staffed outpatient department. Self-referral to the teaching hospital was a favoured option when the need for hi-technology diagnosis was envisaged. The self-directed access to facilities outside the zone often did not follow the referral chain recommended by the Ministry of Health and Child Welfare and in some cases led to the re-ordering of the services. When Shumba residents visited the city, they often took advantage of the state bus company that charged subsidized fares and free service for senior citizens.

7.2.6 Dual Access of Public and Private Health Services

Patients responded to the decline in health services by combining access to both the public and the private sector health services to fill critical gaps in the public sector health delivery system. It was a simultaneous deployment of internal public and internal public exit strategies. Though private provision could be efficient, it was inappropriate for certain types of services, hence the need for public provision in the initial instance. Public health providers routinely referred patients to private institutions for services they were no longer offering. Patients seeking services from public service providers also sought to extract maximum services from the cheaper public sector and blend them with supplements from the more expensive private service. The most common strategy under dual usage was where patients got prescriptions from the council clinics and government hospitals and then procured drugs from the private pharmacies. The strategy was deployed when the public health institutions had personnel but no medicines. It was commonly adopted in Shumba in the face of perennial drug shortage.

The second variant of dual usage was when patients often consulted private doctors and presented prescriptions to Shumba clinic for supply of medicines. The strategy was employed when the clinic had drugs but no appropriately qualified staff in place. Patients with chronic conditions such as hypertension, diabetes and asthma would get service

from the clinic when their condition was under control and would access specialist private services if the condition deteriorated.

The third variant of dual access occurred when patients remained booked in public hospitals but provided their own medicines, in place of those in short supply in the public hospital. The reverse of this variant was when a patient was booked in a private hospital but would be temporarily booked in public institutions to undergo diagnostic tests that were more expensive in the private hospitals. A respondent from Shumba narrated a case where she was referred to the main public referral hospital for specialist treatment. She required having her blood samples taken for laboratory investigations. The public hospital did not have the necessary surgical needles to extract the blood specimen hence the patient had to pay a private laboratory for blood sample extraction and submission of the specimen to a public hospital laboratory.

At Shumba clinic, some patients had to provide their own sterilized water for mixing with powder antibiotic injections. The sterilized water could only be procured from the city pharmacies. Expectant mothers in Shumba were from 2004 required to supply six pairs of latex gloves when they reported to the clinic for delivery, as the clinic usually had no latex gloves in stock. Failure to provide the latex gloves when the clinic was out of stock meant the patient would be referred to the district hospital automatically, a more costly avenue. Women reporting for delivery were also required to bring their own candles and lighters for use in the event of power outages during delivery. Furthermore, all patients hospitalised had to get food from their homes, as the clinic did not provide any.

The fourth variant was a hybrid service where public hospitals cooperated with private physicians. The level-four referral hospitals had wards designated 'private' where patients paid higher cost recovery fees and generally had better facilities and basic medication was usually available. To a large measure, the private wards operated on the same principles as private hospitals and specialist practitioners booked their patients in the cheaper public hospitals. The public hospitals charged the private patient on a cost recovery basis. The private wards in public hospitals such as the Parirenyatwa Group of

Hospitals' D-Floor, offered the hybrid service that was only accessible to the richer segment of society. Agere (1986; 367) described this variant in earlier studies when he noted, "government subsidises private patients of private doctors who have to use government hospitals where sophisticated equipment is available". The dual access to private and public services was complex, encompassing individual action, internal provider exit, internal public exit and occasionally some element of individual voice.

7.2.7 Self Medication

Public health institutions failed to cope with the demand for antiretroviral treatment (ART). There were fewer drugs than patients eligible to be on ART and as a result; public health service providers delayed preparing patients for ART. Faced with imminent death and unable to afford the full costs of the private service some patients opted for the informal market, initiating ART without supervision of a physician. Such patients would commonly end up with severe complications³⁹. Some patients receiving ARVs from public health institutions allegedly opted for the black market when due to the intermittent industrial actions by medical personnel they failed to access services at public health institutions and could not afford private care.

There was still a lot of stigma associated with HIV, AIDS and tuberculosis. Because of the stigma, when some patients suspected they had HIV or tuberculosis they resorted to self-medication instead of seeking diagnostic confirmation and treatment. Some patients receiving treatment under care of health professionals would immediately cease treatment when advised to undergo HIV screening and would resort to self-medication. The HIV and AIDS stigma was pronounced in Shumba where the condition was referred to as "that killer disease of today"⁴⁰.

³⁹ Zimbabwe Television Documentary on HIV and AIDS interview by Dr Ratidzo Ndhlovu broadcast on 10 December 2007.

⁴⁰ An FGD held on 18 September 2007 Shumba revealed that in November 2006 a young man in his early twenties from Shumba was referred to a district hospital for voluntary counseling and testing. He tested HIV positive and committed suicide two days later out of despair.

Self-medication was potentially dangerous as the dosages were not patient specific and there could be repackaging resulting in the loss of directions on the use of medications. Due to increased incidence of poverty, even self-medication was often delayed until people became seriously ill.

7.2.8 Religious Appeal/Spiritualism

Appeal to religion during periods of ill health was common among all religious groups. The main religious groups were traditionalists and Christians. Christians were divided into orthodox, syncretic and Pentecostal⁴¹. One Pentecostal group, Marange sect, with a large following in Shumba did not use hospitals as one of the core principles of its doctrine. The church instead provided its own self-contained health facilities. This church provision of health care was not a direct response to policy failure but attracted citizens frustrated by the implosion in the health sector and sought alternative affordable services. The Marange sect offered a full bouquet of alternative medical services independent of the state. The sect was in Goran Hyden's sense 'uncaptured', existing outside the official system and hence not adversely affected by the decline in state health services.

The church had locations designated for healing *Chidzidzo* (hospital/clinic). The 'hospital' was established at the homestead of a leading faith healer. Patients were referred to the clinic and some were 'hospitalized' for periods ranging from days to years depending on the nature of the ailment and the treatment required. The church was divided into four main departments: judiciary, diviners, medical, and education. The judiciary adjudicated on civil and criminal matters between and involving members of the church. The department of diviners specialized in the diagnosis of both health and social problems and the medical department was composed of healers. The fourth department was the education division staffed by baptists who taught church doctrine. Three of the departments were directly involved in the delivery of health care. A patient was typically first referred to the diviners who diagnosed the medical condition and recommended treatment. The medical department had 'doctors' that offered treatment. The judiciary

⁴¹ Syncretic church "whose practices are a mixture of missionary Christianity and a generous dose of African traditional religion" with its main methods being divination, witch-hunting and healing (PRF 151).

adjudicated over cases, interpreted laws and regulations and dealt with some health problems having a psychological bearing.

The provision of medical services by the Marange sect was fashioned along the lines of modern hospitals. There were general practitioners who treated common conditions and referred patients requiring specialists' attention. The specialists were in the fields of psychiatry, optometrists, paediatrics, gynaecology, dentistry, orthopaedics and gastro. The church also offered antenatal and postnatal services. In some cases, patients were required to visit several specialists that were invariably located in different parts of the country (*kufamba mativi mana*). The dentists routinely performed tooth extractions and the orthopaedics set broken bones and applied plaster. The church policy prohibited charging for consultation services. However, the exchange of gifts in appreciation was encouraged. In the case of midwifery services, the hamper for services was specified: mostly grocery items and a church gown for the richer patients. The guiding principle for gifts was that they remained modest. Some literate midwives maintained elaborate records for their patients that were used to acquire birth registration documents. The death of a child was usually not recorded whilst for adults the records from the church healer that would have attended to the deceased were accepted by the Registrar of Births and Deaths as sufficient death notice for the issuance of death certificates. In a way, the actual child mortality among that sect remained unrecorded and unknown. The Marange sect limited the medical support to members of their church and any person seeking help had to be baptised into the church as a condition for receiving treatment.

The medical services offered by the sect though seemingly primitive in comparison with modern medical practice were effective and satisfied the needs of its members. However, though the church prohibited its members from seeking services from hospitals, members particularly mothers were reported to be increasingly accessing child immunisations secretly. The staff at Shumba clinic indicated that a small number of mothers from the sect had come and indicated willingness to have their children immunised. The hospital personnel kept the records for such children at the clinic to protect the mother and child

against victimisation. The clinic staff indicated that some women from the same church were also accessing contraceptive secretly.

The government was equivocal regarding its antenatal, postnatal and child immunisation policy for the sect members. For reasons of political expediency, the government had been ambivalent about enforcing the national child immunisation policy on sect members who claimed constitutional protection. The government only moved in rare instances when there was a disease outbreak. In Shumba, the Ministry of Health and Child Welfare had been issued several warnings to the Marange sect 'hospital' to close down because of insufficient toilets. However, the threat could not be carried out because the ruling party was facing serious challenges in the general elections held in 2000, 2002, 2005 and March 2008. The government failed to enforce its regulations for fear of backlash of collective voice voting. To church members, the fact that government was aware of their operations and had not taken any punitive measures meant approval. In the words of one senior member of the 'judiciary', "because the government is aware of what we do and does not ban us it follows that it is legal". The sect offered a primitive but parallel medical service that effectively substituted for the failing public health delivery system.

Other religious organisations had different approaches to the Marange sect. For all Pentecostal believers, when ill, the first contact for care was the faith healers and only referring to hospital as a secondary measure. In the event of emergencies such as caused by accidents, the patients consulted the hospital but simultaneously sought the assistance of faith healers. In the orthodox and Pentecostal churches, there was a generous and complex mix of faith healing and modern medicine. It was usual for a patient to be referred to the hospital by the faith healers and still be required to continue receiving spiritual guidance whilst still in hospital.

7.2.9 Traditional Medicines and Herbs

Faced with inadequate modern medicines, rural dwellers resorted to primordial forms of medication. This was especially so in emergencies caused by snakebites, diarrhoea, mild respiratory infections and a variety of malignant cancers. As the snake anti-venom was

only available at the main teaching hospital in the capital, the traditional practitioner offered an effective and life-saving alternative. In Shumba, a poisonous snake bit a 76-year-old man in January 2007. The victim initially got first aid treatment from the local herbalist and upon visiting the district hospital discovered that there was no snake anti-venom. He came back to the village to rely on traditional herbs. By October 2007, he was still on treatment but recovering steadily, able to walk and the numbness in his feet declining.

The reliance on modern medicine had eroded the knowledge, interest and skills of many traditional medical practitioners. The environmental damage caused by uncontrolled veldt fires in post-2000 land reform era resulted in some plant species used as medicines becoming extinct or difficult to obtain.

Essential immunisation drugs such as Bacillus Calmette-Guerin (BCG) that ideally should be administered at birth could be given up to ninety days after birth and in-between the parents often resorted to traditional medicines for immunisations. As noted in PASS II (GoZ 2006, 15) immunisation rates were on the decline: 63% of children having received all immunisations, with polio at 88%, measles 80%, hepatitis 79%, Diptheria-Perstussis-tetanus (DPT) 85% and BCG at 93%. The decline in immunisation levels was a direct consequence of the “weakening health delivery system, shortage of drugs, high staff shortages and presence of child and grandparent headed household due to the HIV and AIDS pandemic” (PRF 2003, 19). The majority of the respondents indicated that they used the traditional medicines for child immunisation in conjunction with the modern immunisation available from the local clinic. The traditional medical practitioner’s diagnosis was still accurate for most child-killer diseases like measles and the treatment regime effective.

There was also an increase in the use of oriental herbs distributed through nationwide marketing networks. However, most of the imported oriental herbs were not approved by the Medicines Control Authority of Zimbabwe (MCAZ)⁴² as they were imported as tea or herbs and then sold as medicines. In Shumba, there was an increased reliance on herbs that were grown in home gardens. This was due to the lack of a robust ART programme in Shumba. The use of herbs was promoted by a women's organisation that provided plant seedlings, drying and marketing facilities for the herbs. *Rosemary*, *moringa*, and *oreganum* classified as immune boosters were commonly used to manage opportunistic infections.

7.2.10 Perverse Coping

As the clinic ran out of medicines, equipment broke down and professional staff left, the Ministry of Health and Child Welfare responded by requiring communities and families to take care of their ill disposed members at home. The family and community were key institutions, in assisting an ill member access health services. Illness of a family member was an extended family concern and assistance for transportation, medicines and other treatment related costs were organised within the extended family framework. One man in an FGD in Shumba aptly summed it, '*kana usina wako unoita mbeva yaorera muriva*' meaning it's difficult to pull through ill health without assistance from one's close relatives and associates.

Prolonged or serious illness affected different members of the families differently and their contributions to the solution were defined by social rank within the family. Female members and children bore the burden of nursing the ill members of the family. When the illness became terminal and the patient required constant nursing then more family members were involved taking turns. In some cases relatives including married siblings and daughters had to relocate temporarily from their matrimonial homes for the duration of the illness. Illness of a parent usually affected the schooling of children as resources ran out and children were withdrawn from school to help in nursing or caring for the

⁴² The MCAZ is mandated to register all new drugs and monitor the quality of drugs sold within the country.

younger siblings. The Poverty Reduction Forum made similar observations (PRF 2003, 84 and 102).

The health delivery system, both private and public remained partly functional due to the ingenuity and resilience of medical professionals who moonlight. Some strategies used by medical staff to augment income were illegal such as stealing medicines, demanding bribes before providing services and under invoicing for procedures. A majority of medical professionals and support staff would sell products to patients and visitors during working hours. In Shumba, the nurses made a brisk business by selling small sachets made from used paper to be used as tablet containers.

As the economic crisis deepened and medical supplies became too expensive or scarce, some medical products were improvised or recycled. Recycling was common with latex gloves when dealing with home based terminally ill patients. Bread wrappers had become the standard substitute for scarce latex gloves but when the bread wrappers became scarce, some home-based care givers resorted to shopping plastic carrier bags instead.

In some cases when patients were given prescriptions to procure drugs from private pharmacies, they bought only the cheaper drugs. An example was a patient from Shumba who when prescribed antibiotics and painkillers bought the cheaper painkillers that did not necessarily treat the disease. Some respondents reported purchasing one antibiotic when two had been prescribed. In the high inflation environment, beginning in 2005 some patients failed to purchase the full course due to a shortage of cash mostly caused by the maximum daily withdrawal limit imposed on individual account holders by the central bank. Upon application, account holders could get the central bank authority to withdraw amounts above the daily limit for medical purposes. However, the approval process took anything from two days to several months. Anecdotal evidence indicated that the payment of bribes shortened the processing time.

7.2.11 Helplessness, Apathy and Substitution

Some people faced with terminal illness and having tried all methods resigned themselves to fate. Some went home hoping for natural recuperation after failing to raise money for transport to go to the referral hospital or for medicines. *'Vanhu vari kufira mudzimba'*, implying premature deaths at home due to treatable diseases was a common comment from respondents. When people became aware that the clinic had no medicines or when the public sector health professionals went on industrial action, some patients did not bother consulting the district hospital and opted to go to the referral centre, congesting higher-level service providers. Some senior citizens could not bear their families selling assets to pay for their medication and hence refused expensive private care as a means of preserving the global family assets and ensuring security of the younger generation.

Life limiting illnesses attracted the most diverse forms of coping ranging from attempts to access high tech modern medicine, traditional medicine, neglect and refusal of treatment as a method of protecting family interests.

7.3 Cross Cutting Responses

The section presents the cross cutting issues in Shumba.

7.3.1 Migration

In Shumba, a significant number of people commuted to Harare on a daily basis. Some were weekly migrants spending the working week in the city and returning to Shumba every weekend or holiday. The daily and weekly migrant workers used the City of Harare medical facilities. The farmers from Shumba also frequently visited the city to market agricultural produce. The farmers took advantage of city marketing trips to access City of Harare or private health services.

7.3.2 Collective Voice via Electoral Process

Elected representatives were often recalled during the scheduled local government elections as a means of registering dissatisfaction with the services. In Shumba the application of collective voice voting was prevalent and since 1980, only one councillor had been retained in an election. The only councillor to be re-elected was to be dismissed

by the Minister of Local Government, Rural and Urban Development in 1987, within six months of being re-elected, for misappropriation of council resources. The community was always 'starting and stopping' community projects spearheaded by the councillors when new councillors assumed office every four years. The main reason for voting out the councillors was that they failed to account for community contributions. In a way, the community used elections as a strategy of protest against poor service delivery, rejecting poor performers and choosing new leaders who promised to deliver. However, the exercise of voice through voting out leadership perceived to be performing poorly did not always contribute to an improvement in service delivery. Though the new leadership was aware of the threat of recall and the need to improve the service quality, the timeframe of four years in office was too short to achieve any significant results. The leadership had to start afresh to mobilise the community after every election.

From interviews, it was apparent that the Shumba community blamed the lax local leadership for the poor state of infrastructure at the clinic. They argued that a committed and visionary leadership would lead to steady recovery. The community was also critical of the higher level leadership, particularly the Provincial Governor and Resident Minister and the Member of Parliament, who they alleged had been imposed on the community by the ZANU-PF leadership and had failed to attend to important issues in the constituency.

The ward councillor was aware of the political undercurrents and in an exit meeting with the researcher in October 2007 was eager to be appraised of the mood of the community. The councillor insisted that since the researcher had been talking to the people he would have an informed opinion about his chances for re-election.

There was a paradoxical scenario when teachers went on strike. Parents opposed the idea of using voice to persuade the teachers to return to class and openly expressed hope that the collective job action by teachers and other civil servants would contribute towards the 'struggle' and instigate forced changes in the national political leadership through the defeat of the ruling ZANU-PF party in the scheduled general elections. A woman in an FGD in Shumba summed up the idea by remarking about the lack of equipment in

schools, “*kana zvimwe zvamunoona kuti zvaramba better kuregera*” meaning, if it is not working it’s just better to cease pretending and stop operating.

Some respondents were of the view that the upcoming elections scheduled for March 2008 presented the most viable opportunity for the exercise of collective voice to reverse the downward trend and access better public goods through a change of government. One parent in Shumba succinctly summed it up, “*Ko ivo vakuru kana vaine madegree vangabudirire kana mwana wangu akasanyora grade seven chaiyo, tichaona kunowira tsvimbo nedohwe*” meaning if the head of state has university degrees then he should be wary of losing the next elections if he denied children the opportunity to complete primary school.

7.4 Conclusion

The Shumba community was successful in leveraging external support for education services. The community survival strategies were complemented by the teacher-based survival techniques. Teachers remained largely present in the sector due to their entrepreneurial activities that enabled them to supplement their meagre public sector incomes. Teachers provided private lessons for a fee and were engaged in a number of informal trading, legal and extra legal ranging from the sale of stationery to trading in foreign currencies at the illegal parallel market.

The private health services maintained relatively high standards of service but were beyond the affordability of the majority. The few who accessed private health facilities relied on remittances from the diaspora as the private health services were increasingly demanding payment in more stable currencies than the Zimbabwean currency. The decline in the provision of health led to a revived reliance on traditional medicines. As noted by Mlambo (1997, 76) traditional medicine played a significant role in the psychological and physical health of the majority of people in Zimbabwe. Under severe stress, the communities also relied on religion or spiritual assistance to deal with their health conditions.

There was also a nuanced way in which patients classified ailments and appropriately referred them to modern medicine, traditional or religious help. It was also common for some illness at different stages to be referred to different providers and sometimes the referral was simultaneous. When patients have to meet the full costs of medical care, they become empowered. They sought more information about the various diagnostic and treatment options, often opting not to take expensive diagnostic tests and medication.

In Shumba, the ease of access to alternative health services in Harare undermined the collective action when required most for the clinic construction project. Excessive collective voice in Shumba by way of recalling representatives was debilitating, as it did not afford the system enough opportunity to recover, leading to a cycle of poor performance leading to more voice and recall and less collective action.

University Of Cape Town

University Of Cape Town

University Of Cape Town

CHAPTER EIGHT: MAOTSA AND SHUMBA IN COMPARATIVE PERSPECTIVE

8.0 Introduction

This chapter compares the responses to the decline in health and education services adopted by the Shumba and Maotsa communities and is divided into three sections. The first section is a comparison of responses in the education sector whilst the second section presents comparisons in the health sector. The third section compares responses on the broad crosscutting issues.

The responses to the decline in health and education services were not uniform but nuanced and influenced by the nature of the geographical area, economic situation, age, and disease profile. Faced with an imploding health delivery system, the medical professionals augmented their meagre public sector salaries by moonlighting and trading. Some responded by seeking fortunes in the diaspora. Patients responded by accessing both the public and the private health delivery facilities and increased use of traditional medicine and spiritualism. Some patients simply failed to respond effectively, acquiesced anticipating a natural recovery of both their ill health and the collapsing health delivery systems and were buried inadvertently under the rubric of the imploding system. In tandem with the macroeconomic decline Zimbabwe experienced from 1997, the health services were on a steady decline and by 2007, reached crisis levels.

The education sector witnessed dramatic declines in government grant allocations. The community raised contributions to fill the funding gap. The two communities had varied success at cooperative action aimed at producing the missing public goods. Support from external actors was critical for the continued delivery of education. The Shumba community was more successful than Maotsa in accessing external resources for the production of education services.

8.1 Education

Both areas had primary schools established during the colonial period that had become old and dilapidated. Though Maotsa had a boarding school, few locals could afford the fees. Both Maotsa and Shumba communities relied on the cheaper council day secondary school established after 1980. As shown in Table 8.1 respondents from both Maotsa and Shumba expressed the opinion that the quality of services provided by their schools was low.

Table 8.1 Respondents' Ratings of Quality of Education Services.

	Shumba	Maotsa	Total
fairly good	4	5	9
neither good nor bad	9	7	16
fairly bad	40	34	74
very bad	1	2	3
don't know	2	3	5
Total	56	51	107

Source: Survey data 2008.

8.1.1 From State Reliance to State Avoidance

In six of the eight schools surveyed, the learner/text book ratio was more than twelve learners to a textbook for the key subjects of Mathematics, English, Science and Shona. In Shumba, the lowest learner textbook ratio of 2:1 was at Mtanahaurwa that had received external support to procure the texts whilst in Maotsa the lowest ratio of 1:1 was at Serima secondary school, a private Catholic school. The textbook situation in the eight schools compares well with the national learner/ textbook ratio of 8:1 in 2003 against a target of 1:1 (GOZ 2006,6). The 2003 second Poverty Assessment Study Survey (PASS II) had also established that the learner textbook ratio was lower in private and mining schools and highest in rural schools in communal areas (GOZ 2006, 6). The Nziramasanga presidential commission on education and training had also estimated the learner textbook ratio to be 4-6 learners per text in rural schools (Nziramasanga 1999, 47).

Four of the five primary schools surveyed had not constructed classrooms for the recently introduced grade zero due to the decline in central treasury support. Only Tsatse primary school in Shumba had begun construction of the grade zero classrooms with the assistance from an international aid organisation.

From 2004, the Basic Education Assistance Module (BEAM) grant payments were delayed for long periods of up to one year. When finally released, the value of the grants had been eroded by inflation. The decline in value of BEAM was set against a background of increased need for public social support due to the deteriorating macroeconomic environment and the rising incidence of poverty. Government policy required school heads to accommodate all learners registered under BEAM. Sending away learners registered to benefit under BEAM for any outstanding charge was perceived as provoking a fight with central government, a fight that the civil servant always lost. In both Maotsa and Shumba, the effect of the reduced value of BEAM was that the vulnerability of a few learners spread across the whole community under the guise of them receiving assistance from the central government. The learners not catered for under BEAM bore the costs on behalf of those purportedly funded under the BEAM programme. In interviews with school heads at Tsatse and Mtanhaurwa primary schools in Shumba; Mukwasi and Mushipe primary schools in Maotsa they indicated that by 2006, the school authorities were discouraging parents from registering for BEAM as a strategy of state avoidance as the grant had been rendered insignificant by the high inflation regime. To the school authorities, the fewer the number of learners relying on the government grants the better it was for the schools as they could legally exclude the learners for the non-payment of fees. This strategy of avoiding the state grants whose value had been eroded by inflation was corroborated by a UNICEF review (2008, 23) which indicates that 35.6% of the total number of schools in Zimbabwe had not submitted claims for the BEAM grants for 2007.

Other fiscal transfers from national treasury to schools in the form of per capita grants disbursed by the Ministry of Education, Sport and Culture to cover tuition and stationery costs were increasingly inadequate in the hyperinflationary environment. The Progressive

Teachers Union of Zimbabwe (PTUZ) indicated that by 2004 the tuition grant was Z\$36 000 dollars per pupil when the basic textbook kit for a grade one learner cost a minimum of Z\$1 million. The situation had deteriorated with the rising inflation each year. For all the eight schools surveyed, by 2007 the tuition grants had become insignificant and insufficient to purchase even a single textbook having been eroded by inflation. The central government transferred the grants into school bank accounts at a time it had become difficult for bank account holders to withdraw cash from their accounts due to maximum daily withdrawal limits imposed by the central bank.

Compounding the problem of the inadequacy of material resources for schools was the challenge of the low government aided teachers' salaries leading directly to high staff turnover and absenteeism. There was also a shortage of teachers qualified to teach the newly established advanced level classes at each of the council secondary schools in Maotsa and Shumba. Serima secondary school maintained a high establishment of teachers as it had better facilities. From 2006, it gave teachers allowances to complement their public sector salaries. In Maotsa, Serima secondary school was the only school that had no problem replacing teachers whilst in others replacements took on average a minimum of a school term. Schools in Shumba could attract replacement staff more easily than those in Maotsa could. This was because Shumba was located near the capital to which many teachers wished to transfer.

8.1.2 Communal Direct Action

From 1980 to 2000, the costs of stationery and textbooks had been financed from a grant from central government and school fees levied on learners. At the turn of the century, fiscal transfers to sub national authorities atrophied in real terms as the government failed to meet its external debt obligations, simultaneously relied more on the ever-increasing domestic debt, and printing money for day-to-day financing. Faced with the declining state support, the school authorities responded by mobilising for communal direct action to provide the public goods and fill the gap left by the defaulting state. The local institutions for education, the school development committees (SDCs) created by government in 1991 provided a viable avenue for the community to participate in

educational matters. The school authorities utilised the committees to extract contributions from communities. The main contributions by learners were in form of extra school fees and various levies to cover costs for stationery, operational costs, special projects and a building fund fee to cover infrastructural development requirements.

The communal direct action was more pronounced in Maotsa where communities financed infrastructural projects whilst in Shumba there was greater reliance on the donors. The continuity of leadership in Maotsa also promoted cooperative efforts as elected representative adopted long-term development plans for the community. In Shumba, the habitual exercise of collective voice voting through recall of representatives during local council elections forced leaders to adopt short-term plans and concentrate on self-aggrandisement, causing disgruntlement and their removal from office. The leadership recall in Shumba therefore created some vicious cycle of leadership at the risk of recall during elections, turning corrupt to maximise gains within the expected short term in office and the recall of corrupt leaders during elections. In Shumba therefore, the excessive use of collective voice voting did not always lead to improvement in the quality of the public services.

The two communities responded differently to a common problem of increasing insecurity at schools. In Shumba, the problem of thefts from schools was so rampant as to threaten school operations whilst in Maotsa it was still a growing problem yet to threaten service delivery. Shumba's close proximity to Harare, availability of public transport to Harare and the thriving informal market for second hand books in Harare were all factors contributing to the problem of thefts from the schools in Shumba. In dealing with the security problem, the Shumba community cooperated and hired local labour from local contributions to provide security. In Maotsa, on the other hand, the community took advantage of the misfortunes of a donor to provide for security at the schools. Despite the differences that in Shumba the security need was imposed on the community whilst in Maotsa the community took advantage of donor misfortunes, the effect in both cases was to redefine the community relations with central government. As communities became

empowered by providing their own security, they became ardent at application of collective voice pressure politics, critical and impatient with the tardiness of the national police force in dealing with the few cases referred to them. The community's involvement in the provision of security as similarly noted in rural Kenya (Francis and Amuyunzu-Nyamongo 2005, 28) led to cases of vigilantism in Shumba.

The post-2004 era witnessed an accelerated erosion of the teachers' incomes due to the rising inflation rates. As a coping strategy, some parents cooperated and contributed towards sustenance of the teachers (who were central government employees) to augment their low salaries. Teachers also received extra payments as a demonstration of gratitude for not joining the nationally organized strikes as happened at Kanongovere primary school or merely to entice the teacher to offer extra lessons during holidays as was the case in Shumba. However, those parents who were poor and whose children were in need of extra tuition were neither aware of the practice nor could afford the private lessons.

The schools administrators' financial record keeping capacities were generally low, as most heads and SDC members were not trained in financial management. It was therefore not possible to establish the exact quantum of pupil's contributions towards education. However, any cost not borne by the donor community (which declined after the imposition of sanctions by the European Union (EU) and US after 2002) was provided directly by learners or the community.

The community action was appropriate for the provision of infrastructure, stationery, salaries and allowances for the teachers and support staff but could not replace the missing functions such as the design of curricula, administration of public examination and teacher training and deployment. That was consistent with OECD/DAC (2008, 14) findings in fragile situations where collective action could not provide the pure public goods.

In all the eight schools surveyed, learners were from late 2002 required to contribute individually to meet all the stationery and textbook costs. However, different schools had different arrangements for organising individual learners' contributions. The option of purchasing extra textbooks was only available to the richer parents and inconceivable for the poor rural majority. The parents who procured additional texts for learners were the quality conscious ones and since they had adopted a private solution to a common problem, they became less concerned with contributing towards the collective solution to the problem of inadequate texts. Because of proximity Harare, with a second hand market for books, the parents in Shumba were more likely to procure private texts than those in Maotsa. In a way, the response in the form of individual direct actions deprived the community of the collective voice of the empowered and quality conscious consumers.

In an environment experiencing deterioration in macroeconomic fundamentals, the poorer parents, who were increasing in number, were unable to afford the compulsory additional individual contributions. Without adequate extra contributions from learners, the schools became inextricably linked to and exhibited the poverty of the host communities. The pupils were not only bearing the larger costs for recurrent expenditure, all the pedagogical materials but were in many cases supplementing the teachers' salaries and allowances directly through the individual learner contributions. In both areas, students compensated for the teachers' absence from duty by forming solidarity study groups. The study groups occasionally received mentorship from senior students.

Working *in lieu* of fees was common in both areas due to the increased incidence of poverty. However, there was in both Maotsa and Shumba an excess supply of labour effectively depressing the labour rates to very minimum levels. The parties providing labour invariably claimed being cheated whilst other parents paying cash argued that labour could still be procured cheaper given the depressed labour market rates. Disputes became protracted if there was a need for a review of fees as those parents who would have contributed labour argued that their labour input was not subject to the same rate of inflation as cash payments for indeed they were usually able to point to some valuable artefact as evidence of their contribution.

The spirit of local collective action persisted despite the adverse economic environment. In a bid to cover the funding gap, communities actively engaged external resource actors.

8.1.3 Leveraging External Support for Direct Action

Both Shumba and Maotsa communities relied largely on external support to finance direct actions. Shumba schools were receiving more support from individuals in the diaspora than Maotsa. In Shumba, the donor input was significant as Mtanhaurwa primary school that had been threatened with closure because of dilapidated infrastructure gradually improved, building new classrooms and achieving the lowest learner textbook ratio as a direct result of external support. In Maotsa, the donor inputs were less significant except for support for school lunches. In both areas, the contributions of individual locals in the diaspora were uncoordinated and *ad hoc* in nature. Similar to observations made by Maphosa (2009, 51), the contributions by Zimbabweans in the diaspora for community activities were not coordinated either from the diaspora or the receiving communities. The diaspora remittances for community activities were invariably *ad hoc* and on a case-by-case and individual donor basis without some conscious effort to coordinate the access to resources from locals based in the diaspora.

Despite leveraging external support, the vulnerable learners remained at risk as the hyperinflation reduced the number of learners that any donor could cover in any year. Increasingly, a large proportion of vulnerable children especially orphans remained without any long-term support surviving on *ad hoc* donations from members of the community.

In accessing external assistance, communities encountered hindrances in the form of government regulations and laws on receipt of gifts by schools. The Ministry of Education, Sport and Culture insisted that its district structures approve every donation to schools. Government was effectively turning the externally generated resources into political patronage products. However, schools routinely subverted the regulation with

impunity, as they did not get clearance from the Ministry of Education, Sport, and Culture to receive donations. In official records, school authorities entered the donations as payments made by relatives targeted towards specific pupils. It was a strategy of minimising obstacles and costs in order to leverage external assistance.

Clientilism though meant to benefit specific parties or individuals could be beneficial to communities (OECD/DAC 2008, 16). School infrastructure provided on a patronage basis in Maotsa improved the quality of service and reduced the costs of education borne by the community. The use of political patronage benefits was prevalent in Maotsa where it fed from intra-party factional competition. Communities took advantage of the electoral competition for support to demand donations for schools and other community projects from politicians aligned to the two main ZANU-PF factions. Political connections were also used to access government resources. Though the rural housing grant was largely unknown in Shumba, in Maotsa it was one of the main sources of revenue for schools infrastructural development.

8.1.4 Teacher Based Strategies as Direct Action

From 2004, the government's support for education declined as the government budget deficit was on the rise. Responses adopted by teachers complemented and made possible a variety of community-based strategies. As a category, teachers responded to the adverse economic conditions by adopting a variety of individual and group based coping strategies. From 2004, the teachers' remuneration had become inadequate for their basic subsistence hence they engaged in income enhancing activities. Teachers augmented their public sector incomes by various strategies mostly, trading, moonlighting and generally using their power to extract resources from the community.

In an interview in October 2007, a Zimbabwe Teacher Association (ZIMTA) representative aptly summed up the situation of members of her union, "there is no teacher in Zimbabwe surviving on salary alone. They are all involved in other income-generating activities to survive. Some strategies are legal whilst others are extra legal". The teachers were particularly involved in cross border trade in both Shumba and

Maotsa. A few teachers worked for brief periods in neighbouring countries and on return trip would import goods for resale in Zimbabwe. Cross-border trading was easier and accessible as civil servants got visas at Republic of South Africa entry ports on the production of pay advice slips; courtesy of an arrangement between the Zimbabwean and South African governments. Such cross border activities resulted in increased absenteeism from duty by the teachers. At all of the eight schools surveyed, there was at least one teacher active in international cross border trade. In Maotsa, the short-term trips to South Africa were common. Due to close proximity to South Africa, a teacher could leave for South Africa after Friday classes and travel to the border town of Musina, shop and manage to be back in class by the following Monday. The teachers were taking individual actions that resulted in them exiting the public sector and relying more on the informal market.

In both Shumba and Maotsa, teachers provided private lessons for a fee. The commercialisation of teachers' skills posed an ethical dilemma for teachers. Parents often accused teachers of not doing enough during official time in order to create a ready market for their services. However, the practice could be viewed as progression in the teaching field as happens in the medical field where professionals from the public sector were free to undertake *locum* duties in the private sector. The response by the teachers was typical of the suffer-manage approach noted by Azarya and Chazan (1998), meant to increase their income and simultaneously covering the teachers against the effects of inflation whilst maintaining their presence in the profession. When the above coping strategies failed to address the problems, teachers left the civil service to join the informal sector or migrate to neighbouring countries.

8.1.5 Voice

Compounding the absenteeism by teachers was the industrial action that led to 'downing of tools' at least once every term from the beginning of 2007 because of grievances over the salary and other conditions of service. The application of collective voice pressure politics through the withdrawal of labour was in sharp contrast to the situation in 2000 when teachers had received 69% to 100% increases on salaries, much higher than the

then prevailing annual inflation rate of 55.9%. Facing an election, ZANU-PF government extended patronage benefits by awarding the huge salary increments. Except for Serima secondary school that paid an allowance to teachers, all schools surveyed were affected by the nationally organised industrial action as teachers exercised collective voice pressure politics. Such labour actions threatened the delivery of education services as the contact time between teachers and learners was drastically reduced. Teachers also took individual actions. In an interview in October 2007, a teacher at Tsatse secondary schools indicated that he had avoided accessing his salary for the previous three months, as doing so would cost him more in transport charges. The decision not to access salary was part of the broader state avoidance strategy.

Teachers were abandoning their posts due to an increase in politically motivated violence. In both Maotsa and Shumba, teachers reported being forced to donate towards ZANU-PF election campaigns during the 2000, 2002 and 2005 elections. The two teachers' unions, the Progressive Teachers' Union of Zimbabwe (PTUZ) and Zimbabwe Teachers Association (ZIMTA), reported an increase in the number of their members who had abandoned duty stations due to an upsurge in political violence in the rural areas during the parliamentary elections in 2000 and 2005 and the presidential elections in 2002. In the build up to the national elections, the teachers who were in the majority of cases polling officers became victims of political violence because of being Movement for Democratic Change (MDC)⁴³ party activists or suspected sympathisers. The victimisation was perpetrated by the rogue elements of the veterans of the liberation struggle and the feared youth militia, the 'Green Bombers'⁴⁴. In August 2001 government had instituted a programme of training youth militia who "became available to discipline their own parents; to attack MDC supporters; and to intimidate teachers and other educated civil servants in rural areas" (Ranger 2005, 221). Kriger (2003, 195) also notes

⁴³ The MDC, formed in 1999 posed the most serious threat to the hegemony of the ruling ZANU-PF since independence. MDC and its supporters were routinely denigrated as traitors and 'sell outs' of the revolution and promoting the interests of the former coloniser. ZANU-PF rhetoric portrayed the MDC as 'free game' for ruling party activists and enthusiasts.

⁴⁴ 'Green Bomber', the nickname for the youth militias, came from the green uniforms the militias wore and the ruthlessness of their approach in 'reeducating counter-revolutionaries'.

similar collusion between ZANU-PF and war veterans to use violence and intimidation against the MDC.

During the 2002 Presidential elections, a teacher at Kanongovere secondary school suspected of being an MDC supporter was instructed by the local ZANU-PF youth league leadership to plead illiteracy before the elections officer so that his assisted vote would make his choice of candidate known. The teacher transferred from the school soon after those elections. In this instance, when political actors hindered the use of collective voice voting, the teachers resorted to external exit strategy. In the run up to the 2005 parliamentary elections, a teacher at Mukwasi was banished temporarily by the ZANU-PF youth because of his known sympathy to the MDC. The ZANU-PF strategy was therefore effective in limiting the free exercise of collective voice voting.

In Maotsa, the practice where learners contributed towards an allowance for the teachers was well established at two schools. No schools had such a practice in Shumba. The 'double dipping' by teachers blurred their reporting responsibilities and obligations to principal employer and the community. The communities that provided teachers additional allowances effectively became subsidiary employers exerting demands on the teachers. The subsidiary employer being locally based was usually able to monitor the behaviour of the teachers and applied collective voice pressure politics to punish them more quickly for any perceived transgression than the remote, centrally based central government employer. The Maotsa community that paid allowances to teachers consequently developed collective voice and had greater influence over the activities of the teachers. The teachers however, resisted being accountable to the community alleging the process was subject to abuse.

The teachers' unions also encountered a dilemma that though they concurred that the extra payments were a practical strategy of keeping teachers alive and in the profession, such payments weakened the unions' ability to exercise collective voice pressure politics through organising industrial actions in quest for improvements of salary and the conditions of service at a national scale. The teachers who received extra allowances

from schools over and above salaries were constrained to join the nationally organised labour actions as payment of the allowance was specifically designed to achieve among other outcomes the continued service by teachers despite the deteriorating economic environment. There was therefore tension between individual teacher's interests and the collective union interests.

The strategy where teachers received extra allowances from the community could not be enduring as the rural communities were not immune to the effects of the economic implosion and their ability to afford extra payments was being constantly compromised. However, what was confounding were the sacrifices the members of community made to maintain their children in school even long after their capabilities appeared exhausted.

In both Maotsa and Shumba, the communities generally argued that they would not like to antagonise the administrators and teachers who spent a lot of time caring for their children. Parents feared that individual complaints could lead to victimisation of their children by the school authorities. Parents preferred to raise concerns at public meetings. Issues would be discussed and issues agreed upon in a caucus prior to official meetings. When one parent raised a contentious issue during the meeting, others would join and support the collective voice. Members voicing as a collective entity felt protected against individual victimisation.

There were cases when the community intentionally subverted government authority in a bid to seek cover against the exposure posed by inconsistent and sometimes outdated regulations. Rather than follow the government requirement to have all fees approved by the Ministry of Education, Sport and Culture, the parents would in a general meeting collectively resolve to give donations to the school. Furthermore, they would 'encourage' all parents and guardians to pay the donations. In effect, they would charge and enforce collection at the same time avoiding central government sanction. The parents remained loyal to state demands to keep the schools operating but simultaneously registered protest against state directions by proceeding against such directions on pegging the levels of

school fees. The Catholic private school was prone to disregard Ministry of Education, Sport and Culture regulation and follow dictates of the church hierarchy.

8.1.6 Exit

Faced with a declining quality of education service, one response was to quit the poor performing school and access the same through better performing actors. Exit from the poor performing education providers took three main forms. The first type of exit of response involved transferring learners from a poor performing council schools to the nearest council school perceived to be offering better service. Learners transferred from Mushipe and Mukwasi primary schools to join Kanongovere primary school in Maotsa and in Shumba learners left Mtanhaurwa primary school for Tsatse primary school. The strategy was long standing but only accelerated during periods of crisis. In Shumba, the learners who could not walk long distances to the preferred schools sought private lodgings in the villages near the schools they were attending. There were no learners in private lodging in Maotsa. The second option involved sending children to private mission schools across the country. In both cases, access to more expensive private education was only accessible to the non-poor category members. The third form of exit was moving children from rural areas to urban areas.

Teachers also resorted to internal public exit. In both Shumba and Maotsa, teachers in day secondary schools who consistently produced outstanding results were offered attractive packages to join the high fee paying boarding schools that had better working conditions. In 2006, Kanongovere secondary school had four of its science and mathematics teachers transferring to neighbouring Serima secondary school that offered better remuneration and working conditions. In Shumba, the head of the history department and long serving staff member left Tsatse secondary school to join a Catholic boarding school in the district.

8.1.7 Helplessness and Apathy

In both areas when a family experienced a shock in the form of prolonged illness, school-going children often dropped out of school to assist in caring for the patient or helping in other household chores such as herding cattle or attending to vegetable gardens. Some

pupils when turned away from school for non-payment of fees were simply too embarrassed to go back without fees and opted out. Others were embarrassed by their levels of poverty especially not having decent clothes and essential material for school such as books and pens and they withdrew in shame.

Across the two areas, teachers adopted perverse strategies when they found themselves without material such as chalk, dusters, pens and record books. The knowledge that the school had no funds to meet the expenditure persuaded some of the teachers to use their own resources. However, it was not a sustainable strategy, as teachers usually did not have sufficient resources to meet the basic requirements for instruction. Whenever they demanded reimbursements from the parents, it was late in coming and parents did not appreciate the generosity of the teachers and suspected them of having used school funds. Both parties invariably felt cheated undermining the potential collaborative efforts in other areas.

In both Shumba and Maotsa, children with disabilities could not be mainstreamed as they were supposed to attend special schools often located in a different district. In that event, most children with disabilities started school when much older and dropped out early or did not attend school at all depending on the severity of their disabilities. Those with severe disabilities requiring specialized attention routinely did not attend school. The Nziramasanga Presidential Commission on education and training (1999, 47) noted the lack of provision for education to children with disabilities and that in the rural areas most disabled children never attended school. Some learners dropped out when they found school too difficult. In Shumba, a young man of seventeen calmly admitted in an FGD to having voluntarily dropped out of school because he found school too difficult. Learners who had learning disabilities were particularly at risk. Continual low grades could be a constant source of stigma forcing them to drop out. In Shumba more than Maotsa, horticulture ventures offered viable alternatives to investment in education.

Individuals though attributing the cause of their problems to the failures of public policy, felt helpless in their ability to make effective demands on the system. In that event, some citizens remained loyal, acquiesced hoping for natural recovery of the system. Acquiescence was consistent with arguments by De Mesquita *et al* (2003) that some citizens remained silent in the face of a decline in the quality of public services as they hoped for the restoration of normal service. Most parents had the notion that it was difficult to change or vote against a proposal presented by the teachers in conjunction with the SDC. In that event, most parents agreed to charges and payments they regarded as being grossly unfair.

Some members of the community loyal to the ruling ZANU-PF party and the government denied the existence and extent of the challenges faced in education. They essentially argued that the situation had been worse during the liberation struggle. To them, the difficulties experienced were part of a predictable cycle and the situation was recoverable.

8.2 Health

There was a marked difference in infrastructure at the clinics at Maotsa and Shumba (see plate 2 for some of the photographic evidence). The Maotsa clinic had better facilities than the Shumba clinic. The buildings at Shumba clinic were grossly inadequate for community needs whilst at Maotsa clinic the infrastructure was superior to an average rural clinic. In Maotsa, the main challenge during the crisis was to maintain the infrastructure and to provide the medicines whilst in Shumba there was an additional demand for basic infrastructure. In Shumba, there was one patient bed for the whole population of 5551, a sharp contrast with Maotsa with 28 beds and an average of 104 people per patient bed. The Maotsa clinic was supplied with reticulated potable borehole water whilst Shumba clinic relied on a manually operated borehole. The telephone communication networks at both clinics were poor. Both clinics did not have operating telephones. The landline telephone at Maotsa clinic had broken down whilst no landline telephone had ever been installed at Shumba clinic. For all communication, the clinics relied on private mobile phones of individual staff and patients.

As shown in Table 8.2, respondents in Maotsa had a more favourable assessment of the quality of general infrastructure at clinic than those in Shumba.

Table 8.2 Respondents' Assessment of the Quality of Health Infrastructure

	Shumba	Maotsa	Total
very good	3	6	9
fairly good	0	40	40
neither good nor bad	1	4	5
fairly bad	24	0	24
very bad	27	0	27
do not know	1	1	2
Total	56	51	107

Source : Survey data 2008.

There were marked disparities in staffing levels between the clinics in Maotsa and Shumba. The Catholic Church guaranteed Maotsa clinic some of the personnel as a nun was invariably a nurse in charge of the clinic. All support staff at Maotsa clinic had been recruited locally and hence could easily broaden their income generation. The Shumba clinic experienced perennial staff shortages and for four years from 2001 to 2004 had to rely on a retired nurse, a local indigene. An earlier study on Zimbabwe by Agere (1986, 362) indicated that rural clinics had since inception at independence in 1980 been perennially understaffed. In Shumba, the community had to grapple with the need to develop infrastructure at the clinic and meet the costs for support personnel. Both clinics offered limited diagnostic services and referred all patients requiring further diagnostic tests to the referral district hospitals.

8.2.1 Collapse of the Primary Health Delivery System 2000-7

The primary health care system that had been the cornerstone of public health delivery in Zimbabwe rapidly deteriorated from the late 1990s. The village community workers who had formed the pillar of the primary health care programme were hardly functional in the two areas by 2007. From a total of fifteen, Village Community Workers (VCW) first established in the early 1980s in both Shumba and Maotsa, only one was active in Shumba by 2007. The active VCW's efforts were spread thinly throughout the ward thereby having little impact.

The VCW's primary mandate was to provide basic health education, first aid, community diagnosis and reporting any community deaths to the health authorities. The non-functioning of the VCW meant that the system of recording and reporting community deaths and disease epidemics at village level was effectively paralysed. The disease patterns, mortality rates and causes of deaths in the communities under study therefore remained unrecorded and largely unknown. In both areas, some births and deaths particularly of children were not recorded. Most rural communities still considered it an expensive optional to register the death of a minor with no estate to administer. In any event, the respondents counted on the inability of the responsible state agencies to catch up with them. For a religious group in Shumba that did not comply with immunisation requirements, reporting deaths of children only invited the much-despised attention of the health authorities.

Common to both clinics was that the salary for all medical professionals was 100 percent grant aided by central government. The medical personnel were therefore equally exposed to the declining public sector salaries.

With a national HIV prevalence of about 20% and the majority of hospital admissions were HIV related⁴⁵ leading to greater demand for common antibiotics for treatment of opportunistic infections. HIV and Aids also led to a rise in the epidemic of TB (PRF 2003, 102). The national response to the HIV pandemic was slow with the first public provision of ARVs being introduced in 2004 (PRF 2003, 127).

HIV and AIDS posed particular challenges to the health delivery system in Zimbabwe. The impact of HIV and AIDS pandemic and the collapsing economy jointly conspired against effective delivery of the health service by the health institutions, both private and public. HIV and AIDS affected the 15-49 years productive age group most (PRF 2003, 81). Even if the supply of the medical services had been constant, the system would still have been constrained by the pandemic. The Ministry of Health and Child Welfare

⁴⁵ Interviews with health personnel at Shumba, Maotsa and referral hospitals (PRF 2003, 102).

surveillance data indicated that by 2003 about 33,7% of the adult population was HIV infected (PRF 2003). The prevalence rate was to fall to about 15.6% by 2007 (National Aids Council 2009). The high HIV prevalence rate resulted in increased cases of opportunistic infections.

The clinics in the two areas had different facilities to deal with the HIV and Aids challenge. The government-supported programme in Shumba though free at the point of consumption, had a long and expensive process of putting patients on ART and a majority of the HIV positive could not afford it. Consequently, there was still a lot of stigma associated with the HIV, as it was truly a “killer disease”. In contrast, Maotsa operated a vibrant ART programme with external support. In Maotsa, HIV afflicted patients on ART were willing to give testimonies about their condition. Despite improved access to facilities to manage HIV and Aids in Maotsa, the pandemic still caused high incidence of illness and deaths. Nationally, 3000 people died each week due to Aids related illness (National Aids Council 2009). Furthermore, at least 90% of the infected people are not aware of their HIV status (National Aids Council 2009) entailing that a majority only become aware of their HIV status when seriously ill.

The responses to the decline in primary health care were not uniform but varied and nuanced, informed by the cost, nature of illness, geography and family capabilities. As discussed in previous Chapter Six and Chapter Seven the common response to the decline in health service was similar to that in education with communities attempting to fill the gap left by government from local sources by creating the public goods.

8.2.2 Local Communal Action

The well-developed infrastructure and longstanding support the Catholic Church extended to the clinic rendered the need for collective action insignificant in Maotsa. However, in Shumba, the community had to deal with the challenge of developing the infrastructure and meeting other costs from cleaning sundries to salaries for support staff that council was no longer able to provide.

The earliest community response strategy to the decline in the health delivery system was for the community to volunteer contributions towards the reconstitution of the services. The community contributions were mostly in the form of volunteer labour, cash and in kind. In Shumba previous failure at cooperative effort reduced trust among community members, limiting the success of any contemporary collective effort. The community had unsuccessfully attempted over the years to develop the clinic from local contributions. Cooperative effort towards improvement of infrastructure at Shumba clinic had fallen victim to the 'free rider problem' as community members did not honour their commitments to contribute to the project. The success at leveraging external resources in other initiatives diverted the attention of the community as they continually hoped to secure a donor to fund the clinic upgrading project. In that regard, success in leveraging external assistance might undermine communal direct actions

Through cooperation of local actors in the health delivery system, medicines were made accessible to desperate cases that would otherwise have gone without as the clinic shared basic drugs in short supply. However, such a system involved horizontal cooperation but lacked documentation and audit trail; provided an opportunity for fraud and misappropriation. In Shumba, the practice of exchanging medicines was limited to exchanges with other council clinics in the area whilst in Maotsa the exchange relations were more diverse. The Maotsa clinic exchanged medicines with the sister Catholic hospital, government clinics and the district hospital.

The HIV and AIDS pandemic had different impacts on the various segments of society who responded in diverse forms. As noted by Francis and Amuyunzu-Nyamongo (2005, 14) in rural Kenya, HIV and AIDS created the need for home based care of sufferers and HIV generally increased the costs of accessing health care. In both areas, but more in Maotsa, the clinic still provided basic health services, the critically ill patients migrated from urban to rural areas adding pressure to the rural health facilities.

The macroeconomic challenges the country faced only served to strain the family structure further. The AIDS pandemic was also reorganizing the family age structure. Its toll was concentrated and most severe on the middle-aged working group with a consequence of many elderly and child-headed families. Under those pressures, the extended family unit was unravelling. Many respondents in Shumba where health facilities were limited, though acknowledging the social responsibility to assist, indicated that they were themselves vulnerable and extension of help to kin as required by culture entailed severe exposure of their own nucleus family members. This finding was consistent with the observation by Trefon (2004, 10) in the DRC that though people offer psychological support, solidarity was limited by “financial and material constraints” as fewer families could afford to extend support in the manner that they did in the past.

8.2.3 Externally Supported Direct Action

In Maotsa, the externally generated resources were critical in provision of basic health services at the clinic. The Catholic Church sourced medicines and equipment for the Maotsa clinic. Because of its weakened state, the government had no capability to influence the allocation and application of any externally generated resources. Donors and NGOs acted independently with little reference to government policy. Government could therefore not direct that more funds be spent say on primary health care as opposed to curative care. Targeting using externally generated resources was determined by the donor’s perception of the problem and not necessarily consistent with objectives of the national primary health policy. Most donors were involved in humanitarian aid for curative elements and few invested in long-term preventive measures.

The finding was consistent with observations by Francis and Amuyunzu-Nyamongo (2005, 13) in Kenya that when local institutions mandated to coordinate NGO activities are weak, the “NGOs, generally operate with minimal government guidance, coordination or constraint”. Indeed most NGOs are persuaded to follow objectives and priorities of external donors even when they could be in conflict with state priorities. Zivetz (2006, 17) also observed the prevalence of state avoidance strategies by NGOs in ‘early recovery fragile states’.

8.2.4 Reordering of Health Service Provision as Direct Action

There was reordering of services in both areas. In Shumba, the clinic assumed functions usually reserved for the district hospital. Despite the lack of necessary facilities such as running water, the Shumba clinic provided maternal care services and delivered babies. In Shumba, the reordering of the services made a service available to a poor population that would have gone without.

In Maotsa, the clinic routinely dispensed medicines that were by policy only to be prescribed by a registered doctor. The community, aware that they were advantaged in receiving a higher level service locally, were grateful and consciously avoided antagonising or voicing against the service providers even in the event that they were dissatisfied with the quality of service. In a way, the direct actions by the health authorities to provide higher-level services undermined the exercise of collective voice.

8.2.5 Self Medication as Individual Direct Action

In both Shumba and Maotsa, self-medication was prevalent as patients commonly visited health centres when illness was at an advanced stage, having first attempted home remedies. Self-medication was a way for patients to compensate directly and individually for those services the public sector could no longer provide. Respondents reported resorting to self-medication even in the case of prescription drugs. Anecdotal evidence indicated that patients got medication ranging from painkillers to antiretrovirals (ARV) from the black market⁴⁶. The president of the Zimbabwe Medical Association (ZIMA) reported that due to economic problems medical practitioners were increasingly presented with patients resistant to the first line ARVs⁴⁷ who would have defaulted on ART. The ZIMA President argued that complications arose from non-compliance resulting from the patients sharing drugs or selling the drugs for other essentials like food.

⁴⁶ The researcher followed up the allegation by going to the popular Mupedzanhemo market in Harare where most goods are traded. Posing as a client wanting to buy ARVs for a sick relative they were made available at a price slightly cheaper than the pharmacy rate. Upon inquiring on how I would know if they were genuine, I was advised that the medicines were 'fresh' from the pharmacy. Further inquiries to establish the exact source were quickly dismissed for wasting time.

⁴⁷ This was from an interview broadcast on Zimbabwe Television at 2000 hours News Hour on 26 June 2007.

The differences in HIV and AIDS stigma levels in Shumba and Maotsa were because of the different levels of access to medical services for those afflicted by HIV. Higher stigma levels resulted in increased cases of self-medication. In Shumba, the chances to begin ART were still minimal and beyond the reach of an ordinary citizen, whilst in Maotsa there was no waiting period for people to be on the programme.

In a study in eastern Zimbabwe, Mararike (1999) argues that some women delayed seeking treatment for fear of hospitalisation and consequent inability to cater for the family during period of hospitalisation.

8.2.7 Exit

Exit from the imploding health services took diverse forms. In Shumba, the health services were generally poorer than those in Maotsa. The first variant of exit coping mechanism was to seek services in the private sector. The private sector constituted two types of institutions, the not-for-profit missionaries and profit oriented private service providers. In both Shumba and Maotsa, access to mission hospitals outside the jurisdiction was resorted to when long periods of hospitalisation were anticipated. Because the clinic at Maotsa continued to offer some basic service, the need for private care in Maotsa was never as desperate as in Shumba.

Access to private services was more prevalent in Shumba due to poorer quality of service offered and its close proximity to a wider range of alternative service providers in neighbouring Harare. In response to a question whether respondents had used private medical services in the previous twelve months, Table 8.3 shows that more people in Shumba accessed private health services than in Maotsa.

Table 8.3 Respondents Accessing Private Medical Services

	Shumba	Maotsa	Total
never	1	16	17
just once or twice	27	30	57
many times	23	5	28
always	5	0	5
Total	56	51	107

Source: Survey data 2008.

Access to private medical facilities was limited to a few non-poor as the private surgeries charged higher rates than public health institutions. Some of the surgeries charged in foreign currency, United States dollars and South African rand in particular or the equivalents in local currency. Some private service providers had formed a cartel that provided services including high technology ambulance services as long as they received prior deposits in offshore foreign currency accounts for example, smallbridge.com insurance company. In that event, the diaspora remittances played a critical role in promoting internal public exit as beneficiaries of remittances access private health care. A small number of people therefore continued to get high technology medical services in the midst of the rubble of the collapsed public health delivery system.

In both areas, patients sought services from similar public institutions in different provinces perceived to be offering a cheaper and better quality service.

8.2.8 Voice

One confounding feature was the lack of exercise of collective voice pressure politics by staff at the two clinics. The personnel at the two clinics did not join the numerous nationally organised industrial actions. They would continue to offer services despite shut downs of the district hospitals due to industrial action. The personnel at the two clinics argue that any withdrawal of service might impact negatively on the community and not lead to improvement of the conditions of service.

There were apparent unequal power relations between the medical staff and the patients to an extent that even when patients' rights were violated, they remained silent, pretended to be ignorant in order to get a service. No patient seemed ready to raise individual voice over poor service directly despite reported abuses by the nurses especially directed against the senior citizens. Most patients had the 'wisdom' of not provoking the medical staff when they needed assistance. Yet some patients particularly in Shumba where the clinic was council owned regarded complaining against clinic staff as tantamount to complaining against the government which was 'treasonous'.

Senior nursing personnel in both Shumba and Maotsa confirmed that there were increased reported cases of abuse of patients in general and against senior citizens and infirm in particular especially by the frustrated, poorly remunerated young professionals who worked without adequate resources. The Zimbabwe Human Development Report (2003, 101) noted that burnout among nursing staff “increased in recent years because of long working hours and difficulties associated with caring for the terminally ill”.

To fully access the public health care, patients took individual initiatives and had to pay a bribe or be extra polite to nursing staff in many cases feigned ignorance and idiocy. In an environment characterized by shortages, the provider of the service had more power and the recipient had to be extra cautious and polite to maintain the limited service. Under those circumstances of penury, exit or protest might not be feasible. When requested to bring saline drip kits, patients instead of complaining against the demands were grateful that when they eventually brought the kit the nurse could perform the procedure at a much reduced cost than in the private sector.

8.2.9 Religious Appeal and Traditional Medicine

In the event of failing to access health services, respondents in the face of prolonged shortage of drugs largely became spiritual. There were a greater number of Pentecostal churches in Shumba compared to Maotsa. Most Pentecostal followers mixed the modern medicine and the spiritual help depending on the nature and length of illness.

The spiritual approach was particularly relevant not only for its diagnostic and treatment capabilities but for the ability to offer prediction and prognosis on future state of health and recommend preventive and precautionary measures. Religion offered an alternative service to the one previously provided by the clinics. The spiritual relief became more pronounced in Shumba with the implosion of the health delivery system. Like spiritual healing, traditional medicine was also specialized on issues related to spiritual wellness. In Shumba, there was more evidence of reliance on spiritualism whilst in Maotsa spiritualism and modern medicine co-existed in the Catholic doctrine.

There was large-scale use of traditional medicines and herbs in both Maotsa and Shumba. When the nature of illness became terminal even ardent Christians reverted to the traditional medical practice for assistance. In some cases, when patients witnessed no improvement with the use of western medicines, they resorted to traditional medicines. Traditional medicine was reputed for its ability to treat specialised conditions particularly psychiatry, infertility, and spiritual related illness. As with religious appeal, most illnesses not cured by modern medicines were regarded as being amenable to traditional medicine.

Traditional medicine was especially critical for establishing the root cause of the ailment or misfortune. In the traditional medicine approach to health, recovery was considered incomplete if the root spiritual causes were not addressed. Believers in traditional religion often found the cause of any ill health, unusual and repeated misfortunes in angry spirits requiring to be propitiated. Medical conditions not cured by modern medicine for whatever reason including lack of drugs and specialist staff was interpreted as having spiritual causes and requiring divine intervention for amelioration. Communities in the two areas therefore routinely hired witch-hunters to cleanse the communities, with invariably disastrous consequences.

The critical shortage of medicines and limited access to specialised care led to complications in diseases that were previously easily treatable. Treatable conditions like diarrhoea were easily classified as having spiritual causes. The use of traditional medicine was also noted by Agere (1986; 361) who argued that the poor resorted to traditional medicine as the only alternative when they failed to access the curative hospitals either due to cost or distance. About 80% of the population was reported to be using the traditional medicines outside the health sector and arguing for the integration of the two systems of medicine, Agere (1986, 371) indicated, “the use of traditional medicine is part and parcel of their culture and the sooner those medicines that do not work are exposed the better”. Agere (1986; 371), was commenting on a situation where there was close collaboration between the Ministry of Health and Child Welfare and the traditional medical practitioners. However, due to economic implosion and weakness in

the health delivery system more citizens relied on traditional medicines not out of choice but by default. Due to weaknesses of the state law-enforcement agents, it was then not possible for state to licence, monitor and regulate the traditional medical practitioner. As a result, many traditional practitioners operated without a licence or regulation posing dangers to patients who had no recourse to redress.

There was a higher prevalent use of herbs to manage the opportunistic infections (OI) in HIV positive patients in Shumba than Maotsa. In Shumba, herbs often formed the basic medication whilst in Maotsa the herbs complemented the antiretroviral treatment.

8.2.10 Helplessness, Substitution and Improvisation

In both Shumba and Maotsa, patients often delayed or never sought specialist treatment when recommended to do so by the local clinic. In response to a question on whether any member of the family had between 2000 and 2007 ever chosen not to get treatment when it was required a majority of respondents as shown in Table 8.4 indicated that it had happened once or twice. In Shumba, two respondents indicated that they always went without medical care when required.

Table 8.4 Respondents Choosing not to Seek Medical Attention.

	Shumba	Maotsa	Total
never	11	5	16
just once or twice	38	42	80
many times	5	4	9
always	2	0	2
Total	56	51	107

Source: Survey data 2008.

The main reason for not seeking specialist treatment was lack of funds and transport. In both areas, there were cases when people occasionally acquiesced after failing to get services. Faced with the problem of lack of ambulance or public transport to referral centres the two communities generally resorted to ancient modes of transportation especially in emergencies. There was widespread use of animal-drawn carts to ferry patients to the hospital in Maotsa from all wealth rank categories. In Shumba, it was mostly the very poor who used the animal-drawn mode of transport, as private vehicles

were available for hire. Even that seemingly cheaper option of animal-drawn carts was not available to all.

Though district hospitals had backup generators to provide electricity in the event of power outages, they often had difficulties procuring sufficient diesel for the generators. At both Maotsa and Shumba, clinics there was reliance on deep freezers and occasionally some vaccines went bad when there were prolonged power outages.

The state of helplessness was not uniform across the two cases. In Maotsa, the Roman Catholic Church offered health services relatively independent of the state and hence communities were not immediately affected by state inability to provide the health care. This was in contrast to Shumba where the Rural District Council failed to offer services and the majority of citizens turned to other public providers outside the jurisdiction and private enterprise.

8.3 Cross Cutting Issues

This section presents issues that cut across health and education. The issues of migration, collective voice voting, participation and broadening of civil servant asset bases are discussed.

8.3.1 Migration

Migration as a variant of external exit was one of the commonest and long-standing strategies employed by Zimbabweans to respond to the decline in the public services and related stressful situations. In response to the general decline in welfare, some citizens coped by way of exiting the space of the failing political system. As a strategy, migration took four main variants.

Firstly, the citizens facing a declining service in the rural areas migrated to urban centres. In 2003, 72% of national migrations were from rural to urban and accounting for 23% of all migrations (GoZ 2006, 144). As noted by Mwanza (1999), the urban areas were perceived to be providing better services and opportunities than the rural areas and hence were a prime destination for the rural populace seeking better services and opportunities.

The movement from the rural to urban areas for better educational facilities continued after the turn of the new millennium up to 2004. The young people were more likely to migrate to the urban areas for better health and education facilities for their families. However, most of the young migrants retained strong links with rural areas of origin and upon reaching retirement age; they relocated back to their rural homes. In Shumba, there was a unique phenomenon of daily migrants commuting between Shumba and Harare.

The migration between rural and urban areas was paradoxical in that the economic fortunes in the destination area were invariably not any brighter. Hyden (2008, 7) commenting on rural to urban migration in Africa stated that it was a phenomenon of 'migration of poverty from countryside to towns'. In Zimbabwe, joblessness and loss of support network often confronted the rural youths who migrated to the urban areas in search of employment as most industries had closed or scaled down.

Secondly, the movement was from the urban centres to the rural areas. In Maotsa, the migrant workers in cities who fell ill often retreated to rural areas for a more reliable and cheaper service. The third variant was emigration to the northern continents of America and Europe. The migration to neighbouring countries mostly South Africa, Botswana, Mozambique and Zambia constituted the fourth variant.

Accurate statistics on the diaspora remittance flows to Zimbabwe are notoriously, "unavailable or inaccessible" (Tevera and Chikanda 2009, 1). Migration abroad was 3 percent in 2003 but increasing due to the poor economic performance of the country (GoZ 2006, 144). Between two and three million Zimbabweans are estimated to have emigrated since 2000 (Tarisayi 2009, 12; The Economist 11 August 2005). There was also a substantial number of Zimbabweans regularly travelling to Botswana, Mozambique, South Africa, and Zambia on trade and shopping trips (Dodson *et al* 2008, 23; Maphsoa (2005).

Migrants remitted cash to support families and relatives back home. In a 2004 study by the Southern African Migration Policy Project, Zimbabweans in the diaspora were

estimated to be remitting an average of R2,759 per migrant annually (Tevera and Chikanda 2009,2). At this estimated remittance transfer rate, a total of two million Zimbabweans in the diaspora would then remit about R5,518 billion annually. The diaspora remittances were used to cover among other expenditures, the cost of health and education. Recipients of diaspora remittances easily afforded higher costs for private sector services in the form of high fees paying boarding schools and private surgeries. As the private health service providers and private schools increasingly demanded payment in foreign currency and goods such as fuel coupons and grocery items they became accessible to the few citizens with access to diaspora remittances.

The common mode of diaspora remittances transfer involved Zimbabwean individuals and corporate with offshore accounts. The remitter would deposit an amount in an offshore account and the recipient would have the equivalent Zimbabwean currency deposited into their Zimbabwe local currency accounts. Following the 2007 Operation Reduce Price, more goods disappeared from the shop shelves and as a response to that development, the mode of diaspora remittance transfers changed from foreign currency to sending goods instead.

The diaspora remittances were individual efforts targeted mostly at family members though occasional donations were made towards community projects such as schools. This was consistent with Maphosa's (2005:15) findings in a study in Mangwe district in southern Zimbabwe that the diaspora remittances were *ad hoc* and uncoordinated and few had been directed at the community level. There was also a superfluity of government regulations that made receiving of donations difficult because public institutions were required to report every donation indicating the source and motive of benefactor. The Shumba community benefited from substantial contributions to community projects by locals in the diaspora more than Maotsa.

Despite improving livelihoods and capabilities of individuals and their immediate families through access to increased income, out migration by the highly skilled personnel impoverished the communities they exited. The doctors, nurses and teachers

were especially difficult to replace and the community being exited had to do with the reduced service or no service once these professionals left the area. Serima secondary school stopped offering advanced level Physics following the departure of the teacher qualified to teach the subject. The young and educated were also more sensitive to the decline of service quality and their departure into diaspora deprives the community the collective voice and ‘contributes to national mediocrity and stagnation’ (Bratton, Chikwana and Sithole, 2005, 99). Exit by the educated elite therefore undermined the exercise of individual and collective voice.

The exodus of qualified personnel also contributed to the deterioration of service and erosion of state authority. In Shumba, respondents mockingly characterised hospitals as ‘paracetamol dispensaries’ where they did not expect to get any meaningful assistance. Increasingly migration became both cause and evidence of the ruling party and the state’s failure to deliver the public goods.

Migration was also an ‘unthinking’ response when reacting to a local threat. This was especially so for teachers who found themselves charged with the ‘heinous’ crime of influencing the rural electorate against the ruling ZANU-PF party. There were more cases of lynching by the ruling party militias reported in Maotsa than Shumba. Rural voters were regarded as guaranteed votes for the ruling party. It was an unpardonable offence to contest the veracity of the untested assumption of the unbreakable bond between ZANU-PF as a liberation movement and the rural constituency. The ruling party regarded the rural constituency’s support of the guerrillas during the liberation war and soon after independence as unconditional and everlasting. The teachers, other civil servants and urban-based visitors to rural areas were often suspected of violating that bond between the rural electorate and ZANU-PF by propagating the “imperialist” ideals of good governance, human rights and freedom of expression.

Migration was sensitive to gender, age, skills levels and destination country’s entry visa regime. However, migration was not always a direct result of the decline in education and health services but was a global response to the multiple problems, including economic

stagnation, lack of political freedom and the inability to enjoy basic human rights. In Yin (2009, 135)'s terms, the phenomenon of migration could be accounted for by a super rival explanation where, "a force larger but including the intervention account for the results".

8.3.2 Collective Voice via the Electoral Process

In both Maotsa and Shumba, the ZANU-PF meetings were up to December 2007 still well attended though the opposition opinion became largely tolerated following the influx of urban migrants dislodged by Operation Restore Order in 2005. The main opposition had been denied space since its formation in 1999. The MDC had despite the violence against its membership and general intimidation contested and fared relatively better in each succeeding election since the referendum in early 2000.

Collective voice against the state and ruling party in the form of protests and demonstrations was regarded by the regime as alien, disobedient externally generated and sponsored by the former colonizer. The ruling ZANU-PF party rhetoric branded voice as being anti nationalist in orientation, not only unpatriotic but also outright treasonous in nature. ZANU-PF party's campaign theme from 2000 was on consolidating sovereignty and empowering the citizens through land redistribution. The government presented the land reform programme as nationalist oriented, pro-poor though going against British colonial interests. In that regard, opposing ZANU-PF was portrayed as being anti-nationalist and counter-revolutionary. The opposition MDC was in the same vein presented as a front of the western world aggrieved by the negative impact of the land reform on their "kith and kin".

The subdued collective voice pressure politics in the form of protest in rural areas might be because most of the aggrieved and likely to protest for change in policy had already taken individualised initiative by emigrating. The record of the regime in handling any form of dissent was also a factor in subdued voice. As aptly observed by Bratton and Masunungure (2006), the ZANU-PF regime used maximum force in response to any popular dissent in the first instance. Exercising collective voice attracted sanctions and

hence people were cautious in its application. The decline in essential services and infrastructure did not necessarily lead citizens to a revolt as might be anticipated in the exit and voice theoretical framework. Instead, the decline had a debilitating effect as citizens individually and rationally concentrated on personal security at the expense of the collective action. In both areas, as agricultural production declined access to adequate amounts of cereal grains became a primary preoccupation rather than the issues of health and education. The availability of external exit through migration also provided an easier option than the group act of voice.

The Zimbabweans in the diaspora continued to exercise individual voice and collective voice pressure politics despite exit and the distance from the state geophysical space. Aided by developments in media technology, Zimbabweans in the Diaspora maintained a significant voice against the decline of services and human rights record in Zimbabwe through the establishment of web based newspapers and campaign groups. However, emigrations entailed the loss of collective voice voting rights.

One confounding factor was the great sense of optimism in the face of adversity. There seemed to be endless hope that the nightmare was ending, that people were in the final phase of the crises, and better days were still to come. This optimism however undermined the development of collective voice as disgruntled citizens invested less in any form of voice anticipating a natural recovery. Also evidently prevalent was the use of humour in very stressful situations. The use of humour in distress is part of the Shona culture of coping with adversity and crises. The Shona culture even has organized purposeful humour during stressful events such as funerals. The decline in the education services with consequent challenges and the plight of civil servants remained a constant source and object of humour and ridicule during the height of the crisis.

8.3.3 Structures for Participation

Each of the two clinics had committees that coordinated citizens' input into clinic administration. The Shumba clinic committee met regularly, at least once every quarter and was more involved in policy matters of the clinic. The committee was responsible for

budgeting and mobilising community contributions towards salaries for support staff. Contrasted to that was a situation in Maotsa where the church was in control and the clinic committee had a consultative and advisory role with little input into the planning and budgeting processes.

Instead, other church structures such as the men and women prayer groups were more influential in organising community contributions. Complaints and suggestions were often channelled through the church structures including the priests. The Sunday service was a popular medium of communicating with the community. In 2004, when there was an outbreak of cattle anthrax in Maotsa, the prayer group meetings and the Sunday mass service became one platform of educating the community about the outbreak, the symptoms of the diseases and the recommended actions.

8.3.4 Broadening of Civil Servant Asset Base

Civil servants from Shumba and Maotsa were also involved in income enhancing ventures. In Shumba, they bought goods from the capital and resold them at schools. Teachers also maintained vegetable gardens and a few did so at a commercial level. In Maotsa, two heads of schools were established shopkeepers. The involvement of teachers in rural trade was a long-standing coping strategy. As the crisis deepened, a majority of civil servants turned to full-time farming with nursing and teaching becoming ancillary vocations. In Shumba, the community detested the farmer teacher as competition whilst in Maotsa teachers received favourable treatment in the allocation of subsidized government inputs. In Maotsa, more than Shumba, teachers sought transfer to home areas in order to reduce transport bills and fully engage in communal agriculture.

8.4 Conclusion

Government provision of public goods was declining at dramatic rate and the common response was for communities to contribute more to compensate for the shortfalls caused by the diminishing public allocations. Between 2000 and 2003, the contributions by the learners were high enough to permit capital development at some schools. The high fee boarding schools purchased a school bus and truck. Over time, the individual community contributions became inadequate to meet school running expenditure the community

resorted to leveraging external support. The Shumba community was more successful than Maotsa in this.

Out migration had been a traditional strategy of coping with crisis and an avenue for capital accumulation since the early colonial days. However, the collapse of the economy after 2000 and the subsequent implosion of the health and education services brought some urgency and redefined the scale and dimensions of migration. By 2007, South Africa was estimated to be host to over two million Zimbabweans.

At the same time, there was an exodus of skilled professionals from Zimbabwe and a growing collective voice was exercised through the electoral processes. Following a petition, government upgraded the two day-secondary schools to advanced level status. Opposition parties took a foothold in Zimbabwean politics gaining support in the rural areas, the traditional ruling ZANU-PF stronghold for political support during elections.

CHAPTER NINE: CONCLUSIONS

9.1 The Study

The study sought to establish rural communities' responses to the lack of capacity or unwillingness by the Zimbabwean state to provide the essential public services in health and basic education. The study chose the two sectors of basic education and health as they provide the key services defining the well-being of a populace. Departing from the extant approaches in political studies that are statist in orientation, the study aimed to establish the adjustments, adaptations and emerging coping strategies by communities in the event of the decline in public services.

Alfred Hirschman's theory of exit, voice and loyalty influenced the theoretical framework guiding the study. The study adapted and reformulated Hirschman's exit, voice and loyalty theory of response to declining services from organisations. The framework adapted for the study postulates that there are several alternative options of responding to the public service decline involving: three types of exit, three dimensions of voice, and three ways of creating the missing public services. The other response options include apathy, passivity, and spiritualism. Two types of loyalty and the degree and nature of political patronage influenced the choice of the response option.

The specific questions raised in this study are: how did communities and households react to the state's failure to provide the essential services in health and education sectors? How did communities and households organize and cooperate to meet the public goods deficits in health and education? What factors (local leadership, economic, and geography) influenced the community responses? A qualitative research design addressed these questions. The study purposefully selected the Maotsa and Shumba communities for their individuality and the diversity they offered. Interviews and focus group discussions were the main methods for data collection. The study used the membership categorization device to analyse the data.

9.2 The dynamics of coping over time and space

The following sections present conclusions of the study, specifying which options were preferred under particular conditions and why? The critical issue is the difference in the coping strategies between the two sectors and the different areas over time and the rationale. This study concludes that under specific conditions, communities prefer particular strategies to others. The adoption of the various coping options was not mutually exclusive as communities often deployed two or more options simultaneously and sequentially as conditions dictated.

The response options chosen by the communities were primarily a function of multiple variables including access to exogenous resources, class and power, political economy, character of local leadership, local community organisational capacity and the degree of material deprivation. Particular response options dominated each of the three phases identified in Chapter Five: 2000 to 2003, 2004 to 2006, and 2007. Voice was dominant in the 2000 to 2003 phase. Exit became the preferred option in the 2004 to 2006 phase. Although communities simultaneously deployed various options at the height of the crisis in 2007, local direct action with support from external resource actors dominated. The following sections trace the dominant coping strategy in each of the three phases.

Dominance of voice, 2000 to 2003

During the early phases of the crises from 2000 to 2003, there was a prevalent use of voice to register discontent with the decline in public services. The state was still able to deliver some basic services when prodded and hence positively responded to individual complaints, electoral losses and industrial strikes by civil servants. In education, government responded to complaints concerning the high costs of education by introducing BEAM, a poverty alleviation programme designed to maintain vulnerable children in school. However, in the main, instead of reconstituting the delivery system, the state chose to pacify voice by dispensing political patronage benefits.

The increases in civil servants' salaries to above the inflation rate in 2000 were designed to gain favour for ZANU-PF as it approached the elections. The rejection of a government-sponsored constitution in 2000 was the first electoral defeat for ZANU-PF since independence. The ruling party responded to that defeat by instituting a land reform programme that involved the often-violent takeover of white owned land that was corruptly redistributed to buy loyalty for ZANU-PF. Both actions increased government expenditure and simultaneously reduced the long-term capacity of the government to deliver services. These responses to voice by government did not take into account the interests of the poorer rural farmers who continued to suffer from the shortages of services and goods. In the 2000 and 2002 elections, the newly formed Movement for Democratic Change garnered significant support, effectively challenging the hegemony of the ruling ZANU-PF party. The electoral voice was then an appropriate and seemingly adequate response option to the rapidly declining socioeconomic situation. During the early phases of the crisis, the exercise of the exit option was minimal as community members successfully used voice to benefit from government-sponsored programmes.

Increased service decline and emergence of exit strategy, 2004 to 2006

The increasing levels of domestic and international debt and the impact of the withdrawal of international financial support further challenged the government's capacity to respond effectively to voice of discontent. The advanced level schools established in both Shumba and Maotsa in response to complaints about the increasing costs of higher secondary education in private schools failed to get any significant funding from the government. Gradually, as the government grants to schools disappeared, the communities responded by mobilising resources locally and from exogenous sources to meet the funding gap. The Shumba community was able to attract donor support because of pre-existing denser networks with donors. With the support from local donors, the Shumba community rebuilt a school that had been threatened with closure due to dilapidated infrastructure. The Shumba community took advantage of being near the capital city and had physical access to the donors and politicians. In Maotsa on the other hand, the community mostly turned to self-help, mobilising local resources to meet the costs for the maintenance of school infrastructure.

As the schools failed to raise funds for learning materials and the quality of services offered declined, the communities resorted to internal public exit, essentially trying to access better quality services from other providers perceived as still offering a better service. In both Maotsa and Shumba, poorly performing schools were deserted for better performing schools within the community. A national policy problem was being recontextualised as a local organisational capacity problem.

The services provided by the Roman Catholic Church in health cushioned the Maotsa residents against the worst effects of the decline thereby minimising the need to seek services from providers outside the community. In Shumba, the decline in health services had immediate and perilous effects as the community relied on the poorly resourced council clinic. The Shumba community then actively mobilised both local and exogenous resources to improve the quality of services offered by the clinic.

The movement of citizens from one part of the country to another influenced the choice of the coping strategy in the 2004 to 2006 phase. The forced relocation through the government initiated Operation *Murambatsvina* in 2005 had two significant effects on community coping strategies. Firstly, the rural-urban migration as a means of coping with the declines in public services was foreclosed as the rural communities realised that those without formal jobs and housing in the urban areas were being forcibly evicted. In that case, the remaining viable exit option was through emigration. Emigrations from Maotsa to South Africa increased from late 2005 into 2006. In Shumba, emigrations were insignificant as Harare remained an attractive destination when seeking employment or engaging in the ever-growing informal sector. Secondly, the forced removal of some urban people and their banishment to the rural areas created a critical mass of citizens opposed to the state and the incumbent government. The victims of Operation *Murambatsvina* no longer had faith in individual voice and sought change through electoral voice. Increasingly, because of the infusion of the disgruntled elements into rural areas and further declines in the quality of the services, the conditions arose for the

MDC to evolve from an urban based into a national party with substantial support in rural areas, the former strongholds of the ruling ZANU-PF party.

Rapid service decline and the adoption of multiple coping strategies, 2007

The crisis deepened and by 2007, the state was failing to provide even the barest of education and health services. There was increased application of voice to register discontent. However, frequent industrial strikes by civil servants had limited impact, as the state was no longer able to respond to the demands of the strikers. To that extent, voice can only be effective when the petitioned party is able to respond without threatening its own welfare. Upon losing faith in the efficacy of voice, the communities complemented individual and collective complaints with more direct action and exit. However, exit and direct action were dependent on costs, access to donor financing, and the migratory history of the community.

Exit reduces pressure on the state to deliver as citizens cease to make any demands on a state that has proved unwilling or unable to deliver. Exit also impoverishes the communities exited and so it is not a very effective response to public policy failure. The propinquity of Maotsa to South Africa resulted in large-scale emigrations from that area to South Africa. In a region characterised by poor agricultural potential, exit became one of the viable means of survival in Maotsa. Emigration was also accessible as it required little cooperation of others and followed routes established for generations. Due to the practical difficulties of obtaining travel documents and the firm view that the government was neither able nor willing to control the borders, illegal emigrations increased. The illegal migrants only encountered hindrances on the South African side where the border was controlled effectively.

The Zimbabwe government welcomed the emigrations for two reasons. Firstly, they assisted government to rid itself of the undesirable dissident voice. Indeed, the government disenfranchised the diaspora community including citizens who had legally emigrated as they were likely to vote against the ruling ZANU-PF. Secondly, the government welcomed the emigrations because they brought in remittances that

cushioned the population against the adverse effects of the ever-declining services. By 2007, an estimated three million Zimbabweans were in the diaspora remitting an estimated R5,5 billion annually. The citizens receiving remittances from the diaspora were able to survive without support from the state. The government even managed to access some of the remittances sent through the legal channels. Indeed, the government encouraged the use of more formal channels for remittance transfers.

As the economy hyper inflated, the government failed to restock the clinics with medicines; grants and salaries rapidly lost value and the communities sought to replace the state. Communities took over the roles previously undertaken by the state as they provided the goods and services directly. However, the communities lacked the organisational capacities and the financial resources to take over state functions and hence largely relied on exogenous resource actors. In health, the missionaries in Maotsa provided basic services obviating deaths and suffering at a time that the state could not provide any meaningful health care services. Donor assistance channeled through government, for example, ARVs in Shumba were free at the point of consumption but expensive to access for a majority of those in need.

Collective action by communities depends on the legitimacy of local leadership to enforce compliance if the collective action dilemma is to be minimised. Maotsa is in a province where factionalism within ZANU-PF is rife. Despite the open divisions within the ruling party, revealing that ZANU-PF was no longer the monolithic unit commanding the loyalty of the majority of the rural population, the victors in the intra-party contests had effective control over party members and to a large extent the local community. Intra-party contests also led to an increase in voicing loyalty in support of ZANU-PF. Therefore, the local leadership in Maotsa had advantage to exact contributions from the community for the rehabilitation of schools. In Maotsa, shirking from community duty was interpreted as supporting the loser in the intra party contests and attracted victimisation. In Shumba on the other hand, there was comparatively greater unity within the ruling ZANU-PF party and different dissenting voices were tolerated. Because differences within the party were tolerated, there were constant changes in the local

leadership as those judged to have failed to deliver and represent were routinely voted out. The resultant frequent changes in local leadership undermined trust and gave rise to the collective action dilemma in Shumba. Despite several initiatives, the community was unable to mobilise resources locally for the upgrading of the clinic infrastructure.

A sense of attachment to schools by the communities influenced their willingness to contribute towards the sustenance of the schools. Communities in rural areas had since colonial times been involved in infrastructure development and administration of schools. Largely, the communities then regarded the schools as community initiatives and were prepared to keep them running despite the lack of the essential support from government. In that regard, the communities blamed the government for making them too poor to operate their schools and not so much for it failing to provide direct support to the schools. Effective decentralization permitting local governments to devolve power and decision-making responsibilities to communities therefore acted as an antidote to state implosion.

The community and the local civil servants also developed ingenious ways of circumventing government regulations when mobilising resources from the community and from external sources for schools. This ingenuity at the local level also involved substitution, belt-tightening to free resources to create the services. By 2007, the communities were prone to ignore the government guidelines since they had become accustomed to government incapacity to enforce its own regulations.

The availability of services in the private sector affected the success of collective action. In Maotsa, there were fewer opportunities to access private services and hence the greater need to rely on the public services. This led to greater cooperation in Maotsa whilst in Shumba the easy access to services in Harare reduced the need to invest in cooperative effort to provide the services locally. The existence of employment opportunities in Harare and income generating through horticulture led many Shumba residents to adopt alternative coping strategies including withdrawing learners from school to pursue commercial ventures. The previous failures at cooperative action in Shumba continually

undermined efforts at collective action whilst in Maotsa previous successes bred trust and an expectation of cooperation. The constant references to the misuse of previous contributions in Shumba undermined the efforts to mobilise resources locally for school and clinic infrastructural developments.

Despite efforts by communities to replace some roles of the state and produce the goods and services directly, voice was in 2007 still used as a complementary strategy. Voice is most effective when government provides something in response to complaints. The electoral voice for the removal of the government meets resistance and becomes a less effective and dangerous route to redress a situation of shortages when state capacity to effectively respond declines. Those citizens who still had faith in their individual and collective capacity to complain and cause change became more tenacious in their criticisms of the state. The teachers went on strike regularly to press for improved conditions of services. Voice by the teachers yielded results as communities responded by offering the teachers incentive allowances. Since the community mobilisation of allowances for teachers required a stable local leadership, the strategy was more successful in Maotsa than Shumba.

The community's response to teachers' strike by offering them extra allowance was not enduring. The receipt of allowance from the community turned subsidiary employer undermined the unity of the teachers' unions as teachers receiving allowances chose not to join the nationally organised strikes. This could be because it was the community that was responding to the voice instead of the state to which voice had been directed. One confounding feature was that the nurses at both Maotsa and Shumba clinics did not join the industrial action by other civil servants despite suffering equal erosion of value of their incomes.

The involvement of the community in paying teachers allowances outside the framework of the government structures led to the establishment of new power relationships between civil servants and the community. The community that increasingly contributed towards the salaries of the civil servants assumed greater control and responsibilities over the civil

servants at the local level. There was inadvertent empowerment of the community over local decision-making and service delivery. However, as the citizens are denied basic services, they become engrossed in the more important matters of the day-to-day survival and vulnerable to manipulation by the state. Because they are resource-constrained and weak, they become malleable.

The availability of external resources influenced the choice of collective action as a response in three ways. In environments characterised by high incidence of poverty, the infusion of external resources makes direct collective action possible. In Shumba, the greater access to donor support enabled the community to contribute towards the reconstruction of one of the schools. The external resources can also lead to delays in mobilising community resources as citizens become dependent on donors. In the case where nongovernmental organisations are well established and able to deliver, then the community will cease to make any demands on the state as it gradually relies on the external agency to provide the services. In Maotsa, the community had poor record and little expectations for the government to deliver health services and overly relied on the Catholic Church for these services. The state welcomed the increased role of the faith-based organisations in service delivery as it reduced pressure on the state to deliver. This was despite the state creating an unfavourable environment for the operations of NGOs and the increased need for humanitarian support for the communities.

The community responses to the decline in health and education services were sometimes unsuccessful. The poorer members of the community failed to respond effectively to the decline. This was especially so for those without access to remittances from the urban areas and the diaspora. Some citizens adjusted demands to suit the reduced supplies of public services and were referring only seriously ill patients to the clinic. In Maotsa, only seriously ill patients received antibiotic medication. By the end of 2007, the coping strategies deployed by communities were strained and generally overwhelmed.

The communities survived the decline in state services by initially complaining. When the government could no longer deliver after complaints, communities resorted to exit

and invariably resolved to provide the goods and services themselves through local efforts. However, due to the lack of organisational and financial capacities the local production of goods was only successful when the communities could access exogenous resources. The main conclusion of this study is that the failure by the state to deliver services at the national level gives rise to a pseudo state that is hollow and unable to perform its functions in health and education. However, the hollowness and inability of the state to deliver public services does not immediately translate into lack of these services at the local level as the communities ingeniously and in varied manner generate strategies to cope with the declines. The nongovernmental organisations, humanitarian organisations and individuals assume the functions previously performed by the state and in a sense, a new private state emerges.

The implications of the study for existing theory is that exit and voice are not the only primary means of responding to unfavourable situations but are only part of the story. When unable to access state services, the communities adapt to surviving on less and provide the goods and services directly.

9.3 Future Research Prospects

The research concentrated on community responses to the state inability to provide the majority of its citizens with health and education services. The areas that could benefit from future research include among others: how 'hollowed states' such as Zimbabwe manage to survive and avert open conflict in the face of the ever declining state capacity and unwillingness to provide the essential public services. Future research could also explore the opportunities for co-production of public services by communities in conjunction with the state.

References

- Agere, S. T. (1986). Progress and Problems in the Health Care Delivery System. In I. Mandaza (Ed.), *Zimbabwe: The Political Economy of Transition 1980-1986* (pp. 355-376). Dakar: CODESRIA.
- Azarya, V., & Chazan, N. (1998). Disengagement from the State in Africa: Reflections on the Experiences of Ghana and Guinea. In P. Lewis (Ed.), *Africa: Dilemmas of Development and Change* (pp. 110-136). Colorado; Oxford: Westview Press.
- Babbie, E. (2004). *The Practice of Social Research* (Tenth ed.). Belmont: Wadsworth Publishers.
- Babbie, E., Mouton, J., Vorster, P., & Prozesky, B. (2005). *The Practice of Social Research* (South African ed.). Cape Town: Oxford University Press Southern Africa.
- Bailey, S. (1995). *Public Sector Economics*. London: Macmillan Press Ltd.
- Baker, C. (2004). Membership Categorization and Interview Accounts. In D. Silverman (Ed.), *Qualitative Research: Theory, Method and Practice* (Second ed., pp. 162-176). London; Thousand Oaks; New Delhi: SAGE Publications.
- Barak, O. (2005). *The Modern Sherwood Forest, Paper presented at the annual meeting of the International Studies Association, Village, Honolulu, Hawaii*. Retrieved July 16, 2009, from http://www.allacademic.com/meta/p71089_index.html.
- Barbour, R. S. (2008). *Introducing Qualitative Research: A student Guide to the Craft of Doing Qualitative Research*. London: SAGE Publications.
- Barnes, T. (2002). Virgin Territory? Travel and Migration by African Women in Twentieth-century Southern Africa. In J. Allman, S. Geiger, & N. Musisi (Eds.), *Women in Colonial Histories* (pp. 164-190). Indianapolis: Indiana University Press.

- Barry, B. (1974). Review Article: 'Exit, Voice and Loyalty'. *British Journal of Political Science* , 4, 79-107.
- Bates, R. H. (2008). *When Things Fall Apart: State Failure in Late Century Africa*. Cambridge; New York: Cambridge University Press.
- Bates, R. H. (2005, January). *Political Insecurity and State Failures in Contemporary Africa*, CID working Paper Number 115. Retrieved June 28, 2007, from Centre for International Development: <http://www.cid.harvard.edu/cidwp/115.htm>.
- Baynham, S. (Ed.). (1992). *Zimbabwe in Transition*. Stockholm: Almqvist and Wiksell International.
- Birch, A. H. (1975). Economic Models in Political Science: the Case of 'Exit, Voice and Loyalty'. *British Journal of Political Science* , 5, 463-482.
- Block, A. (2008). *Gaps in protection: Undocumented Zimbabwean Migrants in South Africa*. *Forced Migration Working Paper series number 14*, University of Witwatersrand. Retrieved April 29, 2009, from http://www.migration.org.za/wp-content/uploads/2008/03/38_BlochZim.pdf
- BMJ Group. (2009, November 12). *HIV Infection CD4 count*. Retrieved November 15, 2009, from <http://www.guardian.co.uk/lifeandstyle/besttreatments/hiv-infection-cd4-count>.
- Borrof, K. E., & Lewin, D. (1997). Loyalty, Voice, and Intent to Exit a Union Firm: A Conceptual and Empirical Analysis. *Industrial and Labor Relations Review* , 51 (1), 50-63.
- Bowman, L. W. (1973). *Politics in Rhodesia: White Power in an African State*. Massachusetts: Harvard University Press.
- Bratton, M., & Masunungure, E. (2006). Popular Reactions to State Repression: Operation Murambatsvina in Zimbabwe. *African Affairs* , 106 (422), 21-45.

- Bratton, M., Chikwana, A., & Sithole, T. (2005). Propaganda and Public Opinion in Zimbabwe. *Journal of Contemporary African Studies* , 23 (1), 77-108.
- Brett, E. A. (c2004). *Systemic Crises, Conflicting Interests and State Failure in Zimbabwe*. Retrieved November 25, 2009, from <http://www.crisisstates.com/download/projectnotes/brett1.pdf>.
- Bryman, A., & Burgess, R. G. (1994). Developments in Qualitative Data Analysis: An Introduction. In A. Bryman, & R. G. Burgess (Eds.), *Analysing Qualitative Data* (pp. 1-17). London: Routledge.
- Buchanan, J. M., & Faith, R. L. (1987). Secession and the Limits of Taxation: Towards a Theory of Internal Exit. *The American Economic Review* , 77 (5), 1023-1031.
- Campbell, R., Dowding, K., & John, P. (2007). Modelling the exit-voice trade-off: Social Capital and Responses to Public Services. *Paper for the Workshop on Structural Equation Modelling: Applications in the Social Sciences on 28 February*. Manchester: Centre for Democracy and Elections, University of Manchester. Retrieved December 14, 2009, from [http://www.lse.ac.uk/collections/government/PSPE/pdf/Sem%20Paper KD 02 07 pdf](http://www.lse.ac.uk/collections/government/PSPE/pdf/Sem%20Paper%20KD%2002%2007.pdf).
- Casley, D. J., & Lury, D. A. (1987). *Data Collection in Developing Countries*. Oxford: Oxford University Press.
- Catholic Commission for Justice and Peace and Legal Resources Foundation. (1997). *Breaking the Silence, Building True Peace: A Report on the Disturbances in Matebeleland and the Midlands 1980-1988*. Harare: Legal Resources Foundation and Catholic Commission for Justice and Peace.
- Central Intelligence Agency (CIA). (2007). *CIA-The World Factbook*. Retrieved April 15, 2008, from <https://www.cia.gov/library/publications/the-world-factbook/geos/xx.html>.

- Central Statistical Office (CSO). (2002a). *Zimbabwe Preliminary Report*. Harare: Government of Zimbabwe.
- Central Statistical Office (CSO). (2002b). *Census 2002 Zimbabwe National Report*. Harare: Government of Zimbabwe.
- Central Statistical Office (CSO). (2001). *Zimbabwe Education Statistics Report*. Harare: Government of Zimbabwe.
- Central Statistical Office (CSO). (1998). *Poverty in Zimbabwe*. Harare: Government of Zimbabwe.
- Chavunduka, G. L. (1994). *Traditional Medicine in Modern Zimbabwe*. Harare: University of Zimbabwe Publications.
- Chazan, N. (1988). Patterns of State-Society Incorporation and Disengagement in Africa. In D. Rothchild, & N. Chazan (Eds.), *The Precarious Balance: State and Society in Africa* (pp. 121-148). Boulder: Westview Press.
- Chigwedere, A. (1991). *The Forgotten Heroes of Chimurenga I: Archives Speak*. Harare: Mercury.
- Chimhete, C. (2007, May 13). *ZIMSEC Chaos Blamed for Virtual Collapse of Examinations System*. Retrieved May 14, 2007, from The Standard: <http://www.thestandard.co.zw/local/11076.html>.
- Chisvo, M. (2000). *Reaping the Whirlwind: Economic Liberalisation and Food Security in Zimbabwe*. London: Catholic Institute for International Relations.
- Chong, D. P. (2003). UNTAC in Cambodia: A New Model for Humanitarian Aid in Failed States. In J. Milliken, *State Failure, Collapse and Reconstruction* (pp. 201-222). Oxford: Blackwell Publishing.
- Chung, F. (2006). *Re-living the Second Chimurenga: Memories from the liberation struggle in Zimbabwe*. Stockholm: The Nordic Africa Institute.

- Chung, F. (1988). Education: Revolution or Reform. In C. Stoneman (Ed.), *Zimbabwe's Prospects: Issues of Race, Class, State and Capital in Southern Africa* (pp. 118-132). Harare: College Press.
- Clapham, C. (2003). The Challenge to the State in a Globalized World. In J. Milliken (Ed.), *State Failure, Collapse and Reconstruction* (pp. 25-44). Oxford: Blackwell Publishing.
- Clark, W. R., Golder, M., & Golder, S. (2006). Power and Politics: Exit Voice and Loyalty Revisted. *Annual Meeting of the American Political Science Association*. Philadelphia: Retrieved October 28, 2009, from http://www.allacademic.com/meta/p_mla_research_citation/5/2/7/1/p152716_index.html.
- Collier, P. (2007). *The Bottom Billion: Why the poorest countries are failing and what can be done about it*. Oxford: Oxford University Press.
- Collier, P., & Hoeffler, A. (2004). Greed and Grievances in Civil war. *Oxford Economic Papers* , 56, 563-565.
- Crowe, S. (2006). Health and Medical Issues in Sub Saharan Africa. In I. Frame (Ed.), *Africa South of the Sahara 2007* (pp. 24-30). London; New York: Routledge.
- Darbon, D. (1992). Fluctuat Nec Mergitur; Keeping Afloat. In S. Baynham (Ed.), *Zimbabwe in Transition* (pp. 1-23). Stockholm: Almqvist and Wiksell International.
- Daronlf, S., & Laakso, L. (2003). *Twenty Years of Independence in Zimbabwe; from Liberation to Authoritarianism*. Houndsmills; Basingdtoke; Hampshire and London: Palgrave Macmillan.
- Dashwood, H. S. (1996). The Relevance of Class to the Evolution of Zimbabwe's Development Strategy, 1980-1991. *Journal of Southern African Studies* , 22 (1), 27-48.

- Davis, B., & Dopcke, W. (1987). Survival and Accumulation in Gutu: Class Formation and the Rise of the State in Colonial Zimbabwe, 1900-1939. *Journal of Southern African Studies* , 14 (1), 64-98.
- de Mesquita, B., Bruce, A. S., Siverson, R. M., & Morrow, J. D. (2003). *The Logic of Political Survival*. Cambridge; Massachusetts: The MIT Press.
- De Soto, H., & Dudwick, N. (2003). Eating from One Pot: Survival Strategies in Moldova's Collapsing Rural Economy. In N. Dudwick, E. Gomart, M. Alexandre, & K. Kuehnast (Eds.), *When Things Fall Apart: Qualitative Studies of Poverty in the former Soviet Union* (pp. 333-377). Washington, D.C: World Bank.
- Devine, F. (1995). Qualitative Methods. In D. Marsh, & G. Stoker (Eds.), *Theory and Methods in Political Science* (pp. 137-153). Houndmills; Basingstoke; Hampshire and London: MacMillan Press Ltd.
- Dodson, B., Simelane, H., Tevera, D., Green, T., & Chikanda, A. (2008). *Gender, Migration and Remittances in Southern Africa, Southern African Migration Project* (Vols. Migration Policy Series, Number 49). Cape Town: Idasa.
- Doornbos, M. (2003). State Collapse and Fresh Restarts: Some Critical Reflections. In J. Milliken (Ed.), *State Failure, Collapse and Reconstruction* (pp. 45-62). Oxford: Blackwell Publishing.
- Dowding, K., & John, P. (2009). The Three Exit, Three Voice and Loyalty Framework: A test with panel survey data on urban services. *Paper to the Midwest Political Science Association Annual Conference April 2-4 2009, panel 60-6 Methodological Advances in Public Administration*. Retrieved November 29, 2009, from http://www.ipeg.org.uk/staff/John/documents/midwest09_3EVL_31_March_2009.pdf.
- Dowding, K., John, P., Mergoupis, T., & Van Vugt, M. (2000). Exit, Voice and Loyalty: Analytic and empirical developments. *European Journal of Political Research* , 37, 469-495.

- Drakakis-Smith, D. W. (1994). Food Systems and the Poor in Harare under Conditions of Structural Adjustment. *Human Geography*, 76 (1), 3-20.
- Du Plessis, A. (2004). State Collapse and Related Phenomena; Select Theoretical Perspectives. In M. Hough, & A. du Plessis (Eds.), *State Failure: The Case of Zimbabwe* (Vol. Ad hoc Publication Number 41, pp. 1-23). Pretoria: Institute of Security Studies, University of Pretoria.
- Duffield, M. (2003). Social Reconstruction and the Radicalisation of Development: Aid as a Relation of Global Liberal Governance. In J. Milliken (Ed.), *State Failure, Collapse and Reconstruction* (pp. 291-310). Oxford: Blackwell Publishing.
- Englebert, P. (2009). *Africa: Unity, Sovereignty, and Sorrow*. Boulder, London: Lynne Rienner Publishers, Inc.
- Europa. (2008). *The Europa World Year Book 2008* (Vol. II). London and New York: Routledge.
- Fanon, F. (1965). *A Dying Colonialism*. New York: Grove Press Inc.
- Ferreri. (2000). *International Public Goods*. Washington DC: World Bank.
- Flyvbjerg, B. (2006). Five Misunderstandings About Case-Study Research. *Qualitative Inquiry*, 2 (12), 219-245. Retrieved December 18, 2008, from <http://qix.sagepub.com/cgi/contents/refs/12/2/219>.
- Foreign Policy. (2005-2009). *The Failed States Index*. Retrieved August 7, 2009, from <http://www.foreignpolicy.com>.
- Francis, P., & Amuyunzu-Nyamongo, M. (2005). *Bitter Harvest: the Social Costs of State Failure in Rural Kenya*. Paper presented to the World Bank Conference, *New Frontiers of Social Policy; Development in a Globalizing World*. Retrieved August 12, 2009, from <http://http://siteresources.worldbank.org/INTRANETSOCIALDEVELOPEMENT/Resources/Arusha.FrancisNyamongoNEW.rev.pdf>

- Gann, L. H. (1969). *A History of Southern Rhodesia: Early Days to 1934*. New York: Humanities Press.
- German Development Co-operation (GTZ). (1999). *Poverty in Zimbabwe: Chapter 1 of the March 1999 Study: The Contribution of Towards 'Poverty Reduction in Zimbabwe'*. Harare: German Development Co-operation.
- Gerring, J. (2004). What is a Case Study and What is it Good for? *The American Political Science Review*, 98 (2), 341-354.
- Gilmurray, J., Riddell, R., & Sanders, D. (1979). *From Rhodesia to Zimbabwe: The Struggle for Health*. Gwelo: Mambo Press.
- Gordon, D. L. (1992). African Politics. In A. A. Gordon, & D. L. Gordon (Eds.), *Understanding Contemporary Africa* (pp. 51-85). Boulder and London: Lynne Rienner Publishers.
- Government of Zimbabwe (GoZ). (2006). *2003 Poverty Assessment Study Survey Final Main Report*. Harare: Government of Zimbabwe.
- Government of Zimbabwe (GoZ). (2004). *Zimbabwe Millennium Development Goals 2004 Progress Report*. Harare: Government of Zimbabwe.
- Government of Zimbabwe (GoZ). (1997). *1995 Poverty Assessment Study Survey Main Report*. Harare: Government of Zimbabwe.
- Government of Zimbabwe (GoZ). (1996a). *Education Act Chapter 25:04, Revised Edition*. Harare: Government of Zimbabwe.
- Government of Zimbabwe (GoZ). (1996b). *Public Health Act Chapter 15:09, Revised Edition*. Harare: Government of Zimbabwe.
- Grootaert, C., & Bastelaer, T. (2002). *Understanding and Measuring Social Capital-A Multidisciplinary Tool for Practitioners*. Washington DC: World Bank.

- Gundani, P. H. (2001). *Changing Patterns of Authority and Leadership: Developments in the Roman Catholic Church in Zimbabwe after Vatican II (1965-1985)*. Harare: University of Zimbabwe Publications.
- Hammar, A., Raftopoulos, B., & Jensen, S. (Eds.). (2003). *Zimbabwe's Unfinished Business: Rethinking Land, State and Nation in the Context of Crisis*. Harare: Weaver Press.
- Hanke, S. H. (2009). *R.I.P. Zimbabwe Dollar*. Retrieved August 13, 2009, from <http://www.cato.org/zimbabwe>.
- Hanke, S. H. (2008). *Zimbabwe: From Hyperinflation to Growth*. Washington D. C. The Cato Institute. *Development Policy Analysis Number 6*. Retrieved August 13, 2009, from <http://www.cato.org/pubs/dpa/dpa6.pdf>.
- Herbst, J. (2004). Let them Fail: State Failure in Theory and Practice; Implications for Policy. In R. Rotberg (Ed.), *When States Fail: Causes and Consequences* (pp. 302-318). Princeton: Princeton University Press.
- Herbst, J. (2000). *State and Power in Africa: Comparative Lessons in Authority and Control*. New Jersey: Princeton University Press.
- Herbst, J. (1996). Responses to State Failure in Africa. *International Affairs*, 21 (3), 120-144.
- Herbst, J. (1990a). *State Politics in Zimbabwe*. Berkeley; Los Angeles; London: University of California Press.
- Herbst, J. (1990b). Migration, the Politics of Protest and State Consolidation in Africa. *African Affairs*, 89 (355), 183-203.
- Herbst, J., & Mills, G. (2003). *The Future of Africa: A New Order in Sight?* Oxford: Oxford University Press.
- Hill, G. (2003). *The Battle for Zimbabwe: the Final Countdown*. Cape Town: Zebra Press.

- Hill, J. (2005). Beyond the Other? A postcolonial critique of the failed state thesis. *African Identities* , 3 (3), 139-154.
- Hirschman, A. O. (1993). Exit, Voice, and the fate of the German Democratic Republic: an essay in conceptual history. *World Politics* , 45 (2), 173-202.
- Hirschman, A. O. (1980). "Exit, Voice, Loyalty": Further reflections and a survey of recent contributions. *The Milbank Memorial Fund Quarterly. Health and Society* , 58 (3), 430-453.
- Hirschman, A. O. (1978). Exit, Voice, and the state. *World Politics* , 31 (1), 90-107.
- Hirschman, A. O. (1970). *Exit, Voice and Loyalty: Responses to Decline in Firms, Organisations and States*. Cambridge, Mass: Harvard University Press.
- Hodder-Williams, R. (c1983). *Conflict in Zimbabwe: The Matebeleland Problem*. London: Institute for the Study of Conflict.
- Holstein, J. A., & Gubrium, J. F. (2004). The Active Interview. In D. Silverman (Ed.), *Qualitative Research: Theory, Method and Practice, Edition* (Second ed., pp. 140-161). London; Thousand Oaks; New Delhi: SAGE Publications.
- Hough, M., & du Plessis, A. (Eds.). (2004). *State Failure: The Case of Zimbabwe* (Vol. Ad hoc Publication Number 41). Pretoria: Institute for Security Studies, University of Pretoria.
- Hyden, G. (c2008). *Why Do Things Happen The Way They Do? A Power Analysis of Tanzania*. Unpublished Report.
- Hyden, G. (2006). *African Politics in Comparative Perspective*. New York: Cambridge University Press.
- Hyden, G. (1983). *No Shortcuts to progress: African Development Management in Perspective*. London: Heinemann.
- Hyden, G. (1980). *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*. Berkeley: University of California Press.

- International Monetary Fund. (2009). *Statement at the Conclusion of an IMF Article IV mission to Zimbabwe*. Retrieved April 19, 2009, from <http://www.imf.org/external/np/sec/pr/2009/pr09993.htm>.
- Jackson, R., & Rosberg I, C. G. (1982). Why Africa's Weak States Persist: The Empirical and Juridical in Statehood. *World Politics* , 35 (1), 1-24.
- Jacobs, B. (2006). The Case of Dangerous Fieldwork. In D. Hobbs, & R. Wright (Eds.), *The Sage Handbook of Fieldwork* (pp. 157-168). London: SAGE Publications.
- Joshi, S. S., & Gandotra, V. S. (2006). Rising Prices and Coping Strategies of Urban Families in India. *International Journal of Consumer Studies* , 30 (1), 55-63.
- Kanyenze, G. (2003). The Performance of the Zimbabwean Economy 1980-2000. In S. Daronlf, & L. Laakso, *Twenty Years of Independence in Zimbabwe; from Liberation to Authoritarianism* (pp. 34-77). Houndmills; Basingstoke; Hampshire and London: Palgrave Macmillan.
- Kaseke, E. (1998). Zimbabwe. In J. Dixon, & D. Macarov (Eds.), *Poverty: A Persistent Global Reality*. New York; London: Routledge.
- Kay, G. (2006). Zimbabwe: Physical and Social Geography. In I. Frame (Ed.), *Africa South of the Sahara 2007* (pp. 1297-1297). London and New York: Routledge.
- Kinyanjui, N. M., & Khayesi, M. (2005). *Social Capital, Micro and Small Enterprises and Poverty Alleviation in East Africa*. Addis Ababa: Organisation for Social Science Research in Eastern and Southern Africa.
- Krause, N., Ellison, C. G., Shaw, A. B., Marcum, J. P., & Boardman, J. D. (2001). Church-Based Social Support and Religious Coping. *Journal for Scientific Study of Religion* , 40 (4), 637-656.
- Kruger, N. J. (2003a). *Guerrilla Veterans in Post-War Zimbabwe: Symbolic and Violent Politics, 1980-1987*. Cambridge: Cambridge University Press.

- Kruger, N. (2003b.). Zimbabwe's War veterans and the Ruling Party: Continuities in Political Dynamics. In S. Daronlf, & L. Laakso, *Twenty Years of Independence in Zimbabwe; from Liberation to Authoritarianism* (pp. 104-121). Houndmills; Basingstoke; Hampshire and London: Palgrave Macmillan.
- Kumar, R. (1999). *Research Methodology. A step-by-step guide for beginners*. London; Thousand Oaks; New Delhi: Sage Publications.
- Laver, M. (1976). 'Exit, Voice and Loyalty' Revisited: The Strategic Production and Consumption of Public and Private Goods. *British Journal of Political Science* , 6, 463-482.
- Ledford, A. (2006, August 31). "*Class Action: Power, Class, and Political Representation in America*". Retrieved October 13, 2009, from Paper Presented at the Annual Meeting of the American Political Science Association, Marriot, Loews Philadelphia and the Pennsylvania Centre: http://www.allacademic.com/meta/p152619_index.html.
- Lewis, P. (Ed.). (1998). *Africa: Dilemmas of Development and Change*. Oxford: Westview Press.
- Leys, R. (1986). Drought Relief in Southern Zimbabwe. In P. Lawrence (Ed.), *World Recession and the Food Crisis* (pp. 258-274). London: Review of African Political Economy, James Currey.
- Lijphart, A. (1971). Comparative Politics and the Comparative Method. *The American Political Science Review* , 65 (3), 682-693.
- Loewenson, R., & Sanders, D. (1988). The Political Economy of Health and Nutrition. In C. Stoneman (Ed.), *Zimbabwe's Prospects: Issues of Race, Class, State and Capital in Southern Africa* (pp. 133-152). Harare: College Press.
- Logan, I. B., & Tevera, D. (2001). Neoliberalism, Regime Survival, and the Environment: the Reform and Agricultural Transformation in Zimbabwe in the 1990s. *Canadian Journal of African Studies* , 35 (1), 99-138.

- Lyons, T. (2004). *Guns and Guerrilla Girls: Women in The Zimbabwean Liberation Struggle*. Trenton; Asmara: Africa World Press, Inc.
- Mackie, T., & Marsh, D. (1995). The Comparative Method. In D. Marsh, & G. Stoker (Eds.), *Theory and Methods in Political Science* (pp. 173-188). Houndmills; Basingstoke; Hampshire and London: MacMillan Press Ltd.
- Mafunda, K. (2007, April 12). *Air Finally Cleared Over Tobacco Season*. Retrieved April 13, 2007, from The Financial Gazette: <http://www.financialgazette.co.zw>
- Mamdani, M. (2008). *Lessons of Zimbabwe*. Retrieved April 19, 2009, from London Review of Books: http://www.lrb.co.uk/v30/n23/mamd01_.html.
- Mandiyani, D. (2008). The Dilemma of Conducting Research Back in Your Own Country as a Returning Student-Reflections of research fieldwork in Zimbabwe. *Area*, 41 (1), 64-71.
- Mandondo, A., & Matose, F. (2008). A Comparative Analysis of adaptive natural resources management in Zimbabwe. In A. Mandondo, R. Prabhu, & F. Matose (Eds.), *Coping Amidst Chaos: Studies on Adaptive Collaborative Management from Zimbabwe*. (pp. 119-132). Bogor: Centre for International Forestry Research.
- Maphosa, F. (2009). *Rural Livelihoods in Zimbabwe: Impact of Remittances from South Africa*. Dakar: CODESRIA.
- Maphosa, F. (2005). *The Impact of Remittances from Zimbabweans working in South Africa on Rural Livelihoods in the Southern districts of Zimbabwe. Forced Migration Working Paper series number 14, University of Witwatersrand*. Retrieved June 17, 2008, from http://www.migration.org.za/wp-content/uploads/2008/03/14_Maphosa.pdf.
- Mararike, C. (1999). *Survival Strategies in Rural Zimbabwe: the Role of Assets, Indigeneous Knowledge and Organisations*. Harare: Mond Books.

- Marotz-Baden, R., & Colvin, L. P. (1985). Coping Strategies: A Rural–Urban Comparison. *Family Relations* , 35 (2), 281-288.
- Mashiri, P. (2003). A Socio-linguistic Interpretation of the Social Meanings of Kinship Terms in Shona Urban Interaction. *Zambezia* , 30 (2), 204-228.
- McCarthy, N. (2004). *Local-level Public Goods and Collective Action. Collective Action and Property Rights. Focus 11 Brief 4 of 16*. Retrieved May 1, 2009, from http://www.mtnforum.org/rs/ol/counter_docdown.cfm?ID=4360.pdf.
- Menkhaus, K. (2003). State Collapse in Somalia: Second Thoughts. *Review of African Political Economy* , 30 (97), 405-422.
- Milliken, J., & Krause, K. (2003). State Failure, State Collapse and State Reconstruction: Concepts, lessons and Strategies. In J. Milliken (Ed.), *State Failure, Collapse and Reconstruction* (pp. 1-21). Oxford: Blackwell Publishing.
- Mlambo, A. (1997). *The Economic Structural Adjustment Programme: The case of Zimbabwe, 1990-1995*. Harare: University of Zimbabwe Publications.
- Moore, D. (2005a). A reply to “The Power of Propaganda: Public Opinion in Zimbabwe 2004”. *Journal of Contemporary African Studies* , 23 (1), 109-119.
- Moore, D. S. (2005b). *Suffering for Territory: Race, Place and Power in Zimbabwe*. Harare: Weaver Books.
- Moyo, J. N. (1992). *The Politics of Administration: Understanding Bureaucracy in Africa*. Harare: SAPES Books.
- Mupedziswa, R., & Gumbo, P. (1998). *Structural Adjustment and Women in Informal Sector Traders in Harare, Zimbabwe. Research Report No 106*. Uppsala, Sweden: Nordiska.
- Muponde, R., & Primorac, R. (Eds.). (2005). *Versions of Zimbabwe: New Approaches to Literature and Culture*. Harare: Weaver Press.

- Mutumukuru-Maravanyika, T., Prabhu, R., Matose, F., Nyirenda, R., & Kozanayi, W. (2008). Facilitating Adaptive Collaborative Management in Forest Landscapes: The Mupfungautsi Case Study. In A. Mandondo, R. Prabhu, & F. Matose (Eds.), *Coping Amidst Chaos: Studies on Adaptive Collaborative Management from Zimbabwe* (pp. 15-64). Bogor: Centre for International Forestry Research.
- Muzondidya, J. (2009). From Bouyancy to Crisis, 1980-1997. In B. Raftopoulos, & A. S. Mlambo (Eds.), *Becoming Zimbabwe: A History from the Pre-Colonial Period to 2008* (pp. 167-200). Harare: Weaver Press.
- Mwanza, A. (1999). *Social Policy in an Economy Under Stress; The Case of Zimbabwe*. Harare: SAPES Books.
- Narayan, D., Patel, R., Schafft, K., Redemacher, A., & Koch-Schulte, S. (2000). *Voices of the Poor: Can Anyone Hear Us?* Washington, D.C: World Bank.
- Narman, A. (2003). Education in Zimbabwe. In S. Daronlf, & L. Laakso (Eds.), *Twenty Years of Independence in Zimbabwe; From Liberation to Authoritarianism* (pp. 140-158). Houndmills; Basingstoke; Hampshire and London: Palgrave Macmillan.
- National Aids Council. (2009). *Zimbabwe's HIV AIDS Situation Analysis*. Retrieved November 9, 2009, from http://nac.org.zw/index.php?option=com_conetent&task=view&id=84Itemid.
- Ncube, G. (2009). The Problem of Health of the Native: Robert A. Askins and Emergence of a New Rural African Medical Care Policy in Southern Rhodesia in the early 1930. *African Comparative History Seminar Series Paper presented on 6 May 2009 at University of Cape Town*. University of Cape Town, Historical Studies Department.
- Ndlovu, N. (2007, May 6). *4 500 teachers quit*. Retrieved May 7, 2009, from The Standard: <http://www.thestandard.co.zw/local/11070.html>

- Nemarundwe, N., & Mutamba, M. (2008). Action Planning and Adaptive Management of Natural Resources in Semi arid Environments: Experiences from Chivi District, Zimbabwe. In A. Mandondo, R. Prabhu, & F. Matose (Eds.), *Coping Amidst Chaos: Studies on Adaptive Collaborative Management from Zimbabwe* (pp. 65-90). Bogor: Centre for International Forestry Research.
- Ness, I. (Ed.). (2009). *The International Encyclopedia of Revolution and Protest, 1500 to the Present* (Vol. VIII). West Sussex: Wiley- Blackwell.
- Nhema, A. (2002). *Democracy in Zimbabwe: From Liberation to Liberalization*. Harare: University of Zimbabwe Publications.
- Nziramasa, C. T. (1999). *Zimbabwe: Report of the Presidential Commission of Inquiry into Education and Training, under Chairmanship of Dr. C. T. Nziramasa to His Excellency, the President. August 1991*. Harare: Government of Zimbabwe.
- O'Callaghan, M., & Austin, R. (1977). *Southern Rhodesia: The Effects of a Conquest Society on Education, Culture and Information*. Paris: UNESCO.
- Olson, M. (1971). *The Logic of Collective Action: Public Goods and the Theory of Groups*. Cambridge; Massachusetts: Harvard University Press.
- Organisation for Economic Cooperation and Development/ Development Assistance Committee (OECD/DAC). (2008). *Service Delivery in Fragile Situations: Key Concepts, Findings and Lessons, OECD/DAC Discussion Paper. Fragile States Group, OECD, Paris*. Retrieved August 11, 2009, from www.oecd.org/dac/fragilestates.
- Ostrom, E. (2007). Collective Action and Local Development Processes. *Sociologica*. Retrieved August 29, 2009, from <http://www.sociologica.mulino.it/doi/10.2383/25950>. , 3, 1-32.
- Ostrom, E. (2005). *Understanding Institutional Diversity*. Princeton: Princeton University Press.

- Ostrom, E., & Walker, J. M. (2003). Heterogeneous Preferences and Collective Action. *Public Choice*, 117 (3/4), 295-314.
- Pankhurst, D. (1988). *Women's Lives and Women's Struggles in Rural Zimbabwe*. Leeds *Southern African Studies*, Number 6:. Leeds: University of Leeds.
- Persyn, P., & Ladriere, F. (2004). The Miracle of Life in Kinshasa: New Approaches to Public Health. In T. Trefon (Ed.), *Reinventing Order in the Congo: How People Respond to State Failure in Kinshasa* (pp. 65-81). London, New York: Zed Books Ltd.
- Poverty Reduction Forum (PRF). (2003). *Zimbabwe Human Development Report 2003, Redirecting our responses to HIV and AIDS, 'Towards reducing vulnerability-the ultimate war for survival'*. Harare: Institute of Development Studies.
- Primorac, R., & Muponde, R. (2005). Introduction: Writing Against Blindness. In R. Muponde, & R. Primorac (Eds.), *Versions of Zimbabwe: New approaches to literature and culture* (pp. xiii-xxii). Harare: Weaver Press.
- Putnam, R. D., Leonardi, R., & Nanetti, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton; NJ: Princeton University Press.
- Quantin, P. (1992). The 1990 General elections in Zimbabwe: A step towards a one party state? In S. Baynham (Ed.), *Zimbabwe in Transition* (pp. 24-44). Stockholm: Almqvist and Wiksell International.
- Raftopoulos, B. (2009). The Crisis in Zimbabwe 1998-2008. In B. Raftopoulos, & A. S. Mlambo (Eds.), *Becoming Zimbabwe: A History from the Pre-Colonial Period to 2008* (pp. 201-232). Harare: Weaver Press.
- Raftopoulos, B. (2007, February 24). *Mugabe Faces Dilemma*. Retrieved February 26, 2007, from The Zimbabwe Independent: <http://www.thezimbabweindependent.com/viewinfo.cfm?linked=21&id=10068&siteid=1>.

- Raftopoulos, B., & Mlambo, A. S. (Eds.). (2009). *Becoming Zimbabwe: A History from the Pre-Colonial Period to 2008*. Harare: Weaver Press.
- Rahmato, D. (1991). *Famine and Survival Strategies: A Case Study from North East Ethiopia*. Uppsala: Nordiska Afrkainstitute.
- Ranger, T. O. (2005). Rule by Historiography: The Struggle over the Past in Contemporary Zimbabwe. In R. Muponde, & R. Primorac (Eds.), *Versions of Zimbabwe: New approaches to literature and culture* (pp. 217-243). Harare: Weaver Press.
- Ranger, T. O. (1985). *Peasant Consciousness and Guerrilla War in Zimbabwe: A Comparative Study*. London: James Currey.
- Ranger, T. O. (1968). African Politics in the Twentieth Century in Southern Rhodesia. In T. O. Ranger (Ed.), *Aspects of Central African History* (pp. 210-245). London; Ibadan; Nairobi: Heinemann.
- Ranger, T. O. (1968). The Nineteenth Century in Southern Rhodesia. In T. O. Ranger (Ed.), *Aspects of Central African History* (pp. 112-153). London; Ibadan; Nairobi: Heinemann.
- Ray, S., & Madzimbamuto, F. (2007). The HIV Epidemic in Zimbabwe-The Penalty of Silence. In R. Primorac, & S. Chan (Eds.), *Zimbabwe in Crisis: The International Response and the Space of Silence* (pp. 45-64). London and New York: Routledge.
- Reno, W. (1998). *Warlords Politics and African States*. Boulder; London: Lynne Reinner Publishers.
- Reserve Bank of Zimbabwe. (2008a). *Half Year Monetary Policy Statement*. Retrieved July 31, 2008, from Reserve Bank of Zimbabwe: <http://www.rbz.co.zw/pdfs/2008Julymps/mps.pdf>.

- Reserve Bank of Zimbabwe. (2008b). *First Quarter Monetary Policy Statement: a Focus on Food, Foreign Exchange Generation, Producer Viability and Increased Supply of Basic Commodities*. Harare: Reserve Bank of Zimbabwe.
- Reserve Bank of Zimbabwe. (2007). *Monetary Policy interim Statement*. Harare: Reserve Bank of Zimbabwe.
- Robert, D. (2002). *A Dictionary of Modern Politics* (Third ed.). London; New York: Europa Publications.
- Rotberg, R. I. (Ed.). (2007). *Worst of the Worst: Dealing with Repressive and Rogue Nations*. Washington D. C.: Brookings Institution Press.
- Rotberg, R. I. (Ed.). (2004). *When States Fail: Causes and Consequences*. Princeton: Princeton University Press.
- Rothchild, D., & Chazan, N. (Eds.). (1988). *The Precarious Balance: State and Security in Africa*. Boulder: Westview Press.
- Rusbult, C. E., Zembrodt, I. M., & Gunn, L. K. (1982). Exit, Voice, Loyalty, and Neglect: Responses to Dissatisfaction in Romantic Involvements. *Journal of Personality and Social Psychology*, 43 (6), 1230-1242.
- Rutherford, B. (2001). *Working on the Margins: Black Workers, White Farmers in Post Colonial Zimbabwe*. Harare: Weaver Books.
- Sachikonye, L. (2002). Whither Zimbabwe? Crisis and Democratization. *Review of African Political Economy*, 29 (91), 13-20.
- Sacks, H. (1992). *Lectures on Conversation* (Vol. 1). (G. Jefferson, Ed.) Oxford: Blackwell.
- Scarnecchia, Timothy; Jocelyn, Alexander and 33 others. (2009). *Lessons of Zimbabwe revisited*. Retrieved June 6, 2009, from <http://www.thezimbabwetimes.com/?p=17482>

- Schegloff, E. A. (2007). A Tutorial on Membership Categorization. *Journal of Pragmatics* , 39, 462-482.
- Shoko, B. (2007, May 13). *Doctors, Nurses Strikes Persists, Cripple Sick Health Delivery*. Retrieved May 15, 2007, from The Standard: <http://www.thestandard.co.zw/local/11079.html>.
- Shoriwa, T. (2007, May 9). *Major Power Cuts Loom*. Retrieved May 9, 2007, from The Herald: <http://www.herald.co.zw>.
- Sick, D. (1997). Coping with Crisis: Costa Rican Households and the International Coffee Market. *Ethnology* , 36 (3), 255-275.
- Singleton, G. (2006). *Social Service Delivery Analysis in Zimbabwe, Second Draft*. Harare: World Bank, Harare.
- Stake, E. R. (2005). Qualitative Case Studies. In K. N. Denzin, & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (3rd ed.). California; London; New Dehli: Sage Publications Inc.
- Stiglitz, J. (1988). *Economics of the Public Sector* (second ed.). New York: W.W Norton and Company Inc.
- Stoneman C, C., & Cliffe, L. (1989). *Zimbabwe- Politics, Economics and Society*. London and New York: Pinter Publishers.
- Suedfeld, P. (1997). Reactions to Societal Trauma, Distress and /or Eustress. *Political Psychology* , 18 (4), 849-861.
- Sylvester, C. (2003). Remembering and forgetting 'Zimbabwe': Towards a third Transition. In P. Gready (Ed.), *Political Transition: Politics and Cultures* (pp. 29-52). London: Pluto Press.
- Tarisayi, E. (2009). Voting in Despair: The Economic and Social Context. In E. V. Masunungure (Ed.), *Defying the Winds of Change: Zimbabwe's 2008 Elections* (pp. 11-24). Harare: Weaver Press.

- Tatic, S., & Walker, C. (Eds.). (2006). *Countries at the Crossroads: A Survey of Democratic Governance*. Lanham; Maryland: Rowan & Littlefield Publishers.
- Tevera, D. S., & Crush, J. (2003). *The New Brain Drain from Zimbabwe* (Vol. Migration Policy Series No 29). Cape Town: Southern African Migration Project, Idasa.
- Tevera, D., & Chikanda, A. (2009). *Migrant Remittances and Household Survival in Zimbabwe* (Southern African Migration Project ed., Vol. Migration Policy Series Number 51). Cape Town: Idasa.
- The Economist. (2005, August 11). *Home Sweet home—for home*. Retrieved November 2009, 2, from http://www.economist.com/world/middleeast-africa/displaystory.cfm?story_id=4277319
- The Herald. (2008, July 22). *Harare Hospital to Offer Free Surgery for Children*. Retrieved July 22, 2008, from The Herald: <http://www.herald.co.zw>
- The Herald. (2008, July 26). *Reduction of Maternal, Neo-natal Mortality Vital*. Retrieved July 28, 2008, from The Herald: <http://www.herald.co.zw>.
- The Standard. (2007, May 6). *Clinic closes down as economic crises deepens*. Retrieved May 7, 2007, from The Standard : <http://www.thestandard.co.zw/local/11064.html>.
- The Zimbabwe Independent. (2009, May 7). *An Inevitable Exodus*. Retrieved May 9, 2009, from The Zimbabwe Independent.: <http://www.thezimbabweindependent.com/index.php/business/22557-an-inevitable-exodus>
- Tibajuka, A. K. (2005, July 18). *Report of the Fact-Finding Mission to Zimbabwe to Assess the Scope and Impact of Operation Murambatsvina by the UN Special Envoy on Human Settlements Issues In Zimbabwe*. Retrieved June 17, 2007, from http://www.un.org/News/dh/infocus/zimbabwe/zimbabwe_rpt.pdf.

- Trefon, T. (2004). Introduction: Reinventing Order. In T. Trefon (Ed.), *Reinventing Order in the Congo: How People Respond to State Failure in Kinshasa* (pp. 1-19). London, New York: Zed Books Ltd.
- Tsiko, S. (2007, May 9). *Brain drain bleeds Africa*. Retrieved May 9, 2007, from The Herald: <http://www.herald.co.zw>.
- UNAIDS. (2008). *Fact sheet Sub Saharan Africa*. Retrieved August 25, 2009, from http://www.data.unaids.org/pub/Fact/2008/epi07_regionalsummary_subsafrica_en_pdf.
- UNDP. (2007). *Human Development Report, Fighting Climate Change, Human Solidarity in a Divided World*. Retrieved August 23, 2009, from http://hdr.undp.org/en/media/HDR_20072008_EN_Complete.pdf.
- UNDP. (2005). *Human Development Report*. Harare: UNDP.
- UNICEF. (2008). *Basic Education Assistance Module (BEAM) Review; Options for Scaling up OVC Education Support, March 2008*. Harare: UNICEF.
- Wainwright, E. (2003). Responding to State Failure-the Case of Austria and Solomon Islands. *Australian Journal of International Affairs*, 57 (3), 485-498.
- Wilkinson, S. (2004). Focus Group Research. In D. Silverman (Ed.), *Qualitative Research: Theory, Method and Practice* (Second ed., pp. 177-199). London; Thousand Oaks; New Delhi: SAGE Publications.
- Williams, P. D. (2006). State Failure in Africa: Causes, consequences and responses. In I. Frame (Ed.), *Africa South of the Sahara 2007* (pp. 37-42). London and New York: Routledge.
- Worby, E. (2003). The End of Modernity in Zimbabwe? 'Passages from Development to Sovereignty'. In A. Hammar, B. Raftopoulos, & S. Jensen (Eds.), *Zimbabwe's Unfinished Business, Rethinking Land, State and Nation in the Context of Crisis* (pp. 49-81). Harare: Weaver Press.

- World Bank. (2008). *Zimbabwe Country Brief*. Retrieved April 19, 2009, from <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/ZIMBABWEEXTN/0,,menuPK:375746~pagePK:141132~piPK:141107~theSitePK:375736,00.html>.
- World Bank. (2003). *World Development Report 2004: Making Services Work for Poor People*. Washington DC: World Bank.
- Yin, R. K. (2009). *Case Study Research: Design and Methods* (Fourth ed.). Los Angeles; London; New Delhi: SAGE.
- Zartman, W. I. (1995). *Collapsed States: The Disintegration and Restoration of Legitimate Authority*. Boulder; London: Lynne Rienner Publishers.
- Zivetz, L. (2006). *Health Service Delivery in Early Recovery Fragile States: Lessons from Afghanistan, Cambodia, Mozambique, and Timor Leste*. Arlington, Va . Retrieved June 31, 2009, from Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development: http://www.basics.org/documents/Early_Recovery_Fragile_States_Zivetz_Final.pdf#serach=%22post%20conflict%20states%20post-conflict%20states%20fragile%20states%22.
- Zvobgo, C. J. (1991). *The Wesleyan Methodist Missions in Zimbabwe*. Harare: University of Zimbabwe Publications.
- Zvobgo, R. (1986). Education and the Challenge of Independence. In I. Mandaza (Ed.), *Zimbabwe: The Political Economy of Transition 1980-1986* (pp. 319-354). Dakar: CODESRIA.
- Zvobgo, R. (1997). *The State, Ideology and Education*. Gweru: Mambo Press.

Appendix A Informed Consent

(Read to all participants before conducting the interview)

My name is Norbert Musekiwa. I am a student registered for a Doctor of Philosophy degree with the University of Cape Town in the Republic of South Africa. My research sets out to investigate how rural households and communities in Zimbabwe have since 2000 adjusted to increasing failure by the state to provide essential health and education services. The study aims to identify and assess the effectiveness of the coping strategies adopted to deal with the deficit of health and education services previously provided by the state.

Before proceeding with this interview, I would like to acquaint you with the conditions of participation and get your informed consent. Participation in this research is strictly voluntary and as a participant you can only provide any information out of your own free will.

I have taken measures to ensure confidentiality and anonymity of respondents. Each participant's right to privacy will be maintained. The names of institutions and individual participants will not be divulged without their consent. Otherwise pseudo names will be used which may not in any way link the participant to the data collected. There will not be any known risk involved in participating in the research.

The end product of the study will be a Doctoral thesis that will be lodged with the University of Cape Town. It is anticipated that some sections of the thesis or the whole thesis might attract publications. The data collected will be available for inspection by the research Supervisors, the Doctoral Degrees Committees and examiners from other institutions as appointed by the University of Cape Town. All the information about participants will be treated with the strictest confidentiality and will not be revealed to anyone else except the parties identified above unless otherwise required by law.

There are no direct benefits for participating in this research except the satisfaction that you have assisted in understanding and dealing with the complex phenomenon of how communities adjust, adapt and cope with declining quality and quantity of public goods.

Do you understand that your participation is voluntary? Do you understand that you will be free to ask questions, withhold any information that you may deem unfit to share, withdraw from participation at any point without penalty? (Wait for an affirmative response before proceeding with the interview).

University Of Cape Town

Appendix B Clearance Letter from Department Social Welfare

*Official communications should
Not be addressed to individuals*

Telephone: Harare 703711/790721-4
Telegraphic Address: 'WELMIN
Fax: 790543/703714



ZIMBABWE

THE DIRECTOR OF SOCIAL SERVICES
P.O. Box CY 429
Causeway
Zimbabwe

Cnr Fourth Street and Central Avenue
HARARE

SW/12/4 | 67

13th May 2008

Mr Norbert Musekiwa
C/o Department of Political and Administrative Studies
University of Zimbabwe
P O Box MP 167
Mount Pleasant
Harare

Dear Sir

**RE: APPLICATION FOR PERMISSION TO UNDERTAKE RESEARCH ON
PROVISION OF EDUCATION AND HEALTH SERVICES TO VULNERABLE
GROUPS**

Your letter dated 22nd April 2008 in connection with the above has reference.

Please be advised that the Department of Social Services has no objection to you undertaking the said research. As such permission is hereby granted for you to interview the District Social Services Officers in Goromonzi and Gutu Districts as per your proposal. At Head Office level, you can make an appointment to interview the undersigned.

This permission is granted on condition that the information obtained is used for your research and academic purposes only.

Wishing you the best.

Yours sincerely

T. A. Chinake
DEPUTY DIRECTOR FOR FAMILY AND CHILD WELFARE
For: **DIRECTOR SOCIAL SERVICES**

Norbert/om

Appendix C Clearance Letter from Ministry of Education, Sport and Culture

Ref: C/426/3

All communications should be addressed to
"The Secretary for Education Sport and Culture"
Telephone: 734051/59 and 734071
Telegraphic address : "EDUCATION"
Fax: 794505



ZIMBABWE

Ministry of Education Sport and Culture
P.O Box CY 121
Causeway
Zimbabwe

Mr. Musakwa
UNIVERSITY OF ZIMBABWE
POLITICAL AND ADMIN DEPT
P.O.M.P. 167
MOUNT PLEASANT

Re: PERMISSION TO CARRY OUT RESEARCH

Reference is made to your application to carry out research in the Ministry of Education, Sport and Culture institutions on:

"STATE FAILURE" IN THE
PROVISION OF EDUCATION AND HEALTH SERVICES
IN ZIMBABWE: ADJUSTMENTS, ADAPTATIONS AND
EVOLVING COPING STRATEGIES OF RURAL
COMMUNITIES: THE CASES OF GOROMONZI & GUTU
DISTRICTS.

Permission is hereby granted. However you are required to liaise with the Provincial Education Director responsible for the schools from which you want to research.

You are also required to provide the Ministry of Education, Sport and Culture with the final copy of your research since it is instrumental in the development of Education in Zimbabwe.

MINISTRY OF EDUCATION
SPORT AND CULTURE
23 APR 2007
I. Gweme
CAUSEWAY

For: SECRETARY FOR EDUCATION, SPORT AND CULTURE

Appendix D Interview Guide for Teachers' Associations

- 1 What are the broad objectives and focus of ZIMTA/PTUZ in Zimbabwe?
- 2 What are the levels of your membership and as a proportion of teachers in Zimbabwe?
- 3 From a Union point, of view what are the main challenges inhibiting the delivery of 'quality education' in Zimbabwe?
- 4 What survival strategies have teachers generated to survive the economic challenges experienced since 2000 both as individual workers and as professionals in the classroom?
- 5 In your opinion are those strategies sustainable?
- 6 Have other parties, that is, government, communities and donors generated any survival and measures to deal with the challenges encountered in provision of education?
- 7 What have been the levels of staff attrition in education sector due to (a) HIV/AIDS; (b) remuneration; and (c) political violence, etc?
- 8 Do rural based teachers enjoy special benefits or endure challenges as compared to urban counterparts?

Appendix E Interview Guide for Ministry of Health and Child Welfare Staff

- 1 What levels of health care institutions exist in Zimbabwe?
- 2 What is the rationale for the different referral/varying levels system?
- 3 How many health institutions exist at each level nationally?
- 4 Who owns those institutions?
- 5 What is the distribution of facilities like hospital beds, doctors, nurses and patients among the various institutions?
- 6 What level of grant assistance to local authorities and mission hospital get from government?
- 7 What has been the Ministry's main focus between preventive and curative care over the past decade?
- 8 How are births and deaths recorded? How are community deaths reported?
- 9 What is the role of the private surgeries and traditional medical practitioner in delivery of health service in Zimbabwe?
- 10 What is the fee paying structure for the varying age groups and types of ailments at Ministry of Health and Child Welfare operated health facilities?
- 11 Who else besides government fund provision of health services?
- 12 What actions did the Ministry to combat the decline in health service standards?
- 13 How many qualified professionals are currently registered?
- 14 Have there been any changes in the last decade?
- 15 How many people are covered by health insurance schemes?
- 16 Does the membership of medical insurance scheme follow any geographic or wealth status?

Appendix F Community Profile and Focus Group Discussion Guide

- 1 What is the name of this community?
- 2 What are the boundaries of the community?
- 3 What are the main identifying features of the community?
- 4 Who are the leaders? (Probe on elected and traditional and their ascribed roles)
- 5 How and who makes decisions that affect the community?
- 6 Are there any existing community projects?

To measure level of infrastructure

- 6 How many schools and clinics are found in the community?
- 7 In your opinion, do these institutions (schools, clinics) provide a good service?

To measure the coping strategies

- 8 If there are no adequate education and health services, how does the community meet the deficit?
- 9 How does the community negotiate for better services from government?
- 10 Does the community leverage any support (from donors and private well wishers)?
- 11 If it gets external support how is it accessed?

Organisational Profile

- 12 What are the important organisations that operate in the area (Probe and check whether they are voluntary or prescribed)
- 13 Who funds these organisations?
- 14 Who makes decisions in these organisations?
- 15 How are stakeholders and community involved in operation of these organisations?
- 16 Rank these organisations in order of importance to your community?
- 17 How do these organisations relate between and among each other?
- 18 What is the focus of each of the identified organisations?
- 19 What is the role of women and the youth in these organisations?

Appendix G Interview Guide for Households

Health Sector

- 1 Which health centre do you go to for primary health care service?
- 2 Which is your next health referral centre?
- 3 How far are the health centers from here (in terms of time or km)?
- 4 How do you rate the quality of the services at the primary health centre?
- 5 How do you rate the quality of the services at the referral centre?
- 6 How do you rate the overall quality of health services provided?
- 7 Has overall quality of health services deteriorated or improved since 2000?
- 8 If there was deterioration, what has particularly declined? (Probe whether it is the quality and number of professional staff, equipment, medicines or a combination)
- 9 Does the decline affect all citizens equally?
- 10 If no probe on which group of people is most affected? (1st and 2nd)
- 11 When did you first notice this decline?
- 12 What actions did you take to deal with the decline? How have you dealt with the problem of the decline in service? (Probe on whether the action sought incorporation into or disengagement from the state. Establish the actual actions taken, e.g. selling of livestock, assets, borrowing or seeking relief from government or/and nongovernmental organisations)
- 13 Since 2000 did you or any member of your family fail to get medical treatment or medicines from the health centre?
- 14 Did you or any member of your family since 2000 ever choose not to seek medical attention when in your opinion they required such services?
- 15 If yes establish if they did so because they lacked fees required or they did not expect to get help from the centre?
- 16 When you did not seek medical attention what specific actions did you take to deal with that problem? (1st, 2nd, 3rd and 4th options)
- 17 What factors informed your actions? (1st, 2nd and 3rd options)
- 18 Do you think that action was/is adequate to contain the challenge?
- 19 Was/Is it sustainable?

- 20 If not what further action will you take?
- 21 Will that action be sustainable?
- 22 In adjusting and coping with the decline in health services, are there any strategies that are particularly sanctioned or encouraged? (Establish the parties that sanction and encourage the specific actions)
- 23 Have you had to help an ill relative or member of community in the last 12 months?
- 24 What was the nature of assistance? (1st, 2nd and 3rd type of assistance)
- 25 Are there people offering private health facilities?
- 26 If yes who are they? (1st, 2nd and 3rd group)
- 27 Have you used the private health services in the last twelve months?
- 28 (a) Are the private services a sustainable alternative to the public facilities?
- 28 (b) Are VCW/HBC active in your community?

Education

- 29 Which school do children from this village go to for preschool, primary and secondary education?
- 30 How far is it from here?
- 31 How do you rate the quality of the services?
- 32 How do you rate the overall quality of education services provided by these institutions?
- 33 Has it deteriorated or improved since 2000?
- 34 If there was deterioration, what has particularly declined? Probe whether it is the quality and number of professional staff, teaching and learning equipment or a combination
- 35 (a) Does the decline affect all citizens equally (probe on whether there is different impact on different wealth ranks and gender)?
- 35 (b) If no probe on which group of people is most affected?
- 36 When did you first notice this decline?
- 37 What actions did you take to deal with the decline? How have you dealt with the problem of the decline in service? (Probe on whether the action sought incorporation into or disengagement from the state.) (1st, 2nd, 3rd, 4th, 5th and 6th)

- 38 Since 2000 was there any member of the household who was of school going age?
(Establish if they were/are in school)
- 39 In the last twelve months did any member of your family fail to get education services due to?
- 40 What specific actions did you take to deal with that problem? (1st, 2nd, 3rd, 4th, and 5th)
- 41 What factors informed your actions? (1st, 2nd and 3rd)
- 42 Do you think that current action was/is adequate and sustainable?
- 43 If not what further action will you take?
- 44 Will that action be sustainable?
- 45 In adjusting and coping with the decline in education services, are there any strategies that are particularly sanctioned or encouraged? (Establish the parties that sanction and encourage the specific actions)
- 46 Have you had to help a relative or member of community with education matters since 2000?
- 47 What was the nature of assistance? (1st, 2nd and 3rd)

Socio Economic Data

- 48 What is your main occupation?
- 49 In the last twelve months what has been your main sources of income? (1st, 2nd, 3rd, 4th, 5th, 6th)
- 50 What is your religion?
- 51 Sex if respondent

Date of interview

Appendix H Coded Interview Guide for Households

Health Sector

1 Which health centre do you go to for primary health care service?

Nyaure Clinic	1	Faith Healers	2	Other	88
Serima Clinic	3				

2 Which is your next health referral centre?

Makumbi District hospital	1	St Joseph Hospital	2	Parirenyatwa	3	Other	88
Driefontain Mission Hospital	4	Gutu District hospital	5	Masvingo Gen Ho	6		

3 How far are the health centers from here (in terms of time or km)?

		Very Near (within 5km)	Near (5-8km)	Far (more than 8Km)	Other
A	Primary health centre	1	2	3	88
B	Referral health centre	1	2	3	88

4 How do you rate the quality of the services at the primary health centre in terms of?

		Very good	Fairly Good	Neither good nor bad	Fairly Bad	Very Bad	Don't know
A	General Infrastructure	1	2	3	4	5	99
B	Hospital beds	1	2	3	4	5	99
C	Number of medical staff	1	2	3	4	5	99
D	Quality of medical staff	1	2	3	4	5	99
E	Availability of medicines	1	2	3	4	5	99
F	Accessibility	1	2	3	4	5	99

5 How do you rate the quality of the services at the referral centre in terms of:

		Very good	Fairly Good	Neither good nor bad	Fairly Bad	Very Bad	Don't know
A	General Infrastructure	1	2	3	4	5	99
B	Hospital beds	1	2	3	4	5	99
C	Number of medical staff	1	2	3	4	5	99
D	Quality of medical staff	1	2	3	4	5	99
E	Availability of medicines	1	2	3	4	5	99
F	Accessibility	1	2	3	4	5	99

6 How do you rate the overall quality of health services provided?

Very good	Fairly good	Neither good nor bad	Fairly Bad	Very Bad	Don't know
1	2	3	4	5	99

7 Has overall quality of health services deteriorated or improved since 2000?

Much worse	Worse	Same	Better	Much Better	Don't know
1	2	3	4	5	99

8 If there was deterioration, what has particularly declined? (Probe whether it is the quality and number of professional staff, equipment, medicines or a combination)

	Professional staff	Equipment	Drugs	Other
	A	B	C	D
Quality	1	1	1	1
Quantity	2	2	2	2

9 Does the decline affect all citizens equally?

Yes	No	Do not know
1	2	99

10 If no probe on which group of people is most affected? (1st and 2nd)

Widows	Orphans	Senior citizens	People without external support from relatives
1	2	3	4

11 When did you first notice this decline?

2000	2001	2002	2003	2004	2005	2006	2007	2008
1	2	3	4	5	6	7	8	9

12 What actions did you take to deal with the decline? How have you dealt with the problem of the decline in service? (Probe on whether the action sought incorporation into or disengagement from the state. Establish the actual actions taken, e.g. selling of livestock, assets, borrowing or seeking relief from government or/and nongovernmental organisations) (1st, 2nd, 3rd, 4th, 5th, 6th and 7th)

Sought service outside the public sector	1	Approached NGOs/donors	8
Raise it with village head	2	Sought the intervention of influential people	9
Raise it with Councilor	3	Took no action	10
Raise it with political party leaders	4	Offered to contribute from personal resources	11
Raised it in community meetings	5	Sold assets	12
Demonstrated or protested	6	Other actions	88
Approached central government	7		

13 Since 2000 did you or any member of your family fail to get medical treatment or medicines from the health centre?

		Never	Just once or twice	Many times	Always
A	Diagnostic services (X-rays and laboratory tests)	1	2	3	4
B	Medicines	1	2	3	4
C	Consumables (e.g bandages)	1	2	3	4
D	Staff	1	2	3	4
E	Electricity	1	2	3	4

14 Did you or any member of your family since 2000 ever choose not to seek medical attention when in your opinion they required such services?

Never	1	Just once or twice	2	Many times	3	Always	4
-------	---	--------------------	---	------------	---	--------	---

15 If yes establish if they did so because they lacked fees required or they did not expect to get help from the centre. (1st, 2nd)

Lacked money	1	Did not expect to get help	2	Lacked transport	3	Other	88
--------------	---	----------------------------	---	------------------	---	-------	----

16 When you did not seek medical attention what specific actions did you take to deal with that problem? (1st, 2nd, 3rd and 4th options)

Home remedies	Spiritual help	Traditional healers	Resign (hoping for natural recovery or waiting for eventual death)	Other
1	2	3	4	88

17 What factors informed your actions? (1st, 2nd and 3rd)

Religion	1	Economic condition	2	Nature of illness	3	Other	88
----------	---	--------------------	---	-------------------	---	-------	----

18 Do you think that action was/is adequate to contain the challenge?

Yes	1	No	2	Do not Know	99
-----	---	----	---	-------------	----

19 Was/Is it sustainable?

Very sustainable	Sustainable	Partially Sustainable	Not sustainable	Do not know
1	2	3	4	99

20 If not what further action will you take? _____

21 Will that action be sustainable?

Yes	1	No	2	Do not Know	99
-----	---	----	---	-------------	----

22 In adjusting and coping with the decline in health services, are there any strategies that are particularly sanctioned or encouraged? (Establish the parties that sanction and encourage the specific actions)

	Religion	Traditional leaders	Central Government	Local Government	Others
	A	B	C	D	E
Seek service outside the public sector	1	1	1	1	1
Raise it with village head	2	2	2	2	2
Raise it with Councilor	3	3	3	3	3
Raise it with political party leaders	4	4	4	4	4
Raise it in community meetings	5	5	5	5	5
Demonstrating or protesting	6	6	6	6	6
Approaching central government	7	7	7	7	7
Approaching NGOs/donors	8	8	8	8	8
Seeking the intervention of influential people	9	9	9	9	9
Taking no action	10	10	10	10	10
Offering to contribute from personal resources	11	11	11	11	11
Selling assets	12	12	12	12	12
Other actions	88	88	88	88	88

23 Have you had to help an ill relative or member of community in the last 12 months?

Never	1	Just once or twice	2	Many times	3	Always	4
-------	---	--------------------	---	------------	---	--------	---

24 What was the nature of assistance? (1st, 2nd and 3rd type of assistance)

Medicines	1	Hospital fees	2	Transportation	3	Household Chores	4	Other	88
-----------	---	---------------	---	----------------	---	------------------	---	-------	----

25 Are there people offering private health facilities?

Yes	1	No	2	Do not Know	99
-----	---	----	---	-------------	----

26 If yes who are they? (1st, 2nd and 3rd group)

Registered health practitioners	Moonlighting Health Practitioners	Religious groupings	Traditional Medical practitioner	Other
1	2	3	4	88

27 Have you used the private health services in the last twelve months?

Never	1	Just once or twice	2	Many times	3	Always	4
-------	---	--------------------	---	------------	---	--------	---

28 (a) Are the private services a sustainable alternative to the public facilities?

Yes	1	No	2	Do not Know	99
-----	---	----	---	-------------	----

28 (b) Are the following active in your community?

	Very active	Active	Not active	Non existent	Do not know
B Village health workers	1	2	3	4	99
C Home based care givers	1	2	3	4	99

Education

29 Which school do children from this village go to for preschool, primary and secondary education?

	Local	Boarding	Urban	Other
A Primary	1	2	3	88
B Secondary	1	2	3	88

30 How far is it from here?

	Very Near (within 5km)	Near (5-8km)	Far (more than 8Km)	Other
A Primary school	1	2	3	88
B Sec. school	1	2	3	88

31 How do you rate the quality of the services in terms of:-

Primary school		Very good	Fairly Good	Neither good nor bad	Fairly Bad	Very Bad	Don't know
A	General Infrastructure	1	2	3	4	5	99
B	Classrooms	1	2	3	4	5	99
C	Teachers' Houses	1	2	3	4	5	99
D	Quality of staff	1	2	3	4	5	99
E	Books	1	2	3	4	5	99
F	Other learning aids	1	2	3	4	5	99
Secondary school							
G	General Infrastructure	1	2	3	4	5	99
H	Classrooms	1	2	3	4	5	99
I	Teachers' Houses	1	2	3	4	5	99
J	Quality of staff	1	2	3	4	5	99
K	Books	1	2	3	4	5	99
L	Other learning aids	1	2	3	4	5	99

32 How do you rate the overall quality of education services provided by these institutions?

Very good	Fairly good	Neither good nor bad	Fairly Bad	Very Bad	Don't know
1	2	3	4	5	99

33 Has it deteriorated or improved since 2000?

Much worse	Worse	Same	Better	Much Better	Don't know
1	2	3	4	5	99

34 If there was deterioration, what has particularly declined? Probe whether it is the quality and number of professional staff, teaching and learning equipment or a combination

	Professional staff	Books	Learning Aids	Other
	A	B	C	D
Quality	1	1	1	1
Quantities	2	2	2	2

35 (a) Does the decline affect all citizens equally (probe on whether there is different impact on different wealth ranks and gender)?

Yes	1	No	2	Do not know	99

35 (b) If no probe on which group of people is most affected? _____

36 When did you first notice this decline?

2000	2001	2002	2003	2004	2005	2006	2007	2008
1	2	3	4	5	6	7	8	9

37 What actions did you take to deal with the decline? How have you dealt with the problem of the decline in service? (Probe on whether the action sought incorporation into or disengagement from the state.) (1st, 2nd, 3rd, 4th, 5th and 6th)

Sought service outside the public sector	1	Approached NGOs/donors	8
Raise it with village head	2	Sought the intervention of influential people	9
Raise it with Councilor	3	Took no action	10
Raise it with political party leaders	4	Offered to contribute from personal resources	11
Raised it in community meetings	5	Sold assets	12
Demonstrated or protested	6	Other actions	88
Approached central government	7		

38 Since 2000 was there any member of the household who was of school going age. (Establish if they were/are in school)

Yes	1	No	2

39 In the last twelve months did any member of your family fail to get education services due to?

		Never	Just once or twice	Many times	Always
A	Absent teachers	1	2	3	4
B	Lack of books	1	2	3	4
C	Lack of learning aids	1	2	3	4
D	Fees	1	2	3	4
E	Top up payments	1	2	3	4

40 What specific actions did you take to deal with that problem? (1st, 2nd, 3rd, 4th, and 5th)

Sought service outside the public sector	1	Approached NGOs/donors	8
Raise it with village head	2	Sought the intervention of influential people	9
Raise it with Councilor	3	Took no action	10
Raise it with political party leaders	4	Offered to contribute from personal resources	11
Raised it in community meetings	5	Sold assets	12
Demonstrated or protested	6	Other actions	88
Approached central government	7		

41 What factors informed your actions? (1st, 2nd and 3rd)

Religion	1	Economic condition	2	Sex of student	3	Other	88
----------	---	--------------------	---	----------------	---	-------	----

42 Do you think that current action was/is adequate and sustainable?

Very sustainable	Sustainable	Partially Sustainable	Not sustainable	Don't know
1	2	3	4	99

43 If not what further action will you take? _____

44 Will that action be sustainable?

Yes	1	No	2	Do not know	99
-----	---	----	---	-------------	----

45 In adjusting and coping with the decline in education services, are there any strategies that are particularly sanctioned or encouraged? (Establish the parties that sanction and encourage the specific actions)

	Religion	Traditional leaders	Central Government	Local Government	Others
	A	B	C	D	E
Seek service outside the public sector	1	1	1	1	1
Raise it with village head	2	2	2	2	2
Raise it with Councilor	3	3	3	3	3
Raise it with political party leaders	4	4	4	4	4
Raise it in community meetings	5	5	5	5	5
Demonstrating or protesting	6	6	6	6	6
Approaching central government	7	7	7	7	7
Approaching NGOs/donors	8	8	8	8	8
Seek the intervention of influential people	9	9	9	9	9
Took no action	10	10	10	10	10
Offering to contribute from personal resources	11	11	11	11	11
Selling assets	12	12	12	12	12
Other actions	88	88	88	88	88

46 Have you had to help a relative or member of community with education matters since 2000?

Never	1	Just once or twice	2	Many times	3	Always	4
-------	---	--------------------	---	------------	---	--------	---

47 What was the nature of assistance? (1st, 2nd and 3rd)

School Fees	1	Books and stationery	2	Uniforms	3	Other	88
-------------	---	----------------------	---	----------	---	-------	----

Socio Economic Data

48 What is your main occupation?

Subsistence Farmer (producing for own consumption)	1	Government employee	4
Peasant Farmer (producing for own consumption and getting surplus for sale)	2	Other	88

Commercial Market Gardner	3		
---------------------------	---	--	--

49 In the last twelve months what has been your main sources of income? (1st, 2nd, 3rd, 4th, 5th, 6th)

Wage or a salary?	1	Borrowing money from a bank?	6
Market gardening	2	Receiving money from family members working elsewhere in the country?	7
Buying and selling goods as a trader?	3	Receiving money from family members working outside the country?	8
Doing work in-kind for food or shelter?	4	Other sources	88
Borrowing money from friends or family?	5		

50 What is your religion?

Traditional religion	1	Atheist	5
Roman Catholic	2	Anglican	6
Salvation Army	3	None	7
Pentecostal	4	Other	88

51 Sex if respondent

Male	1	Female	2
------	---	--------	---

52 Community where respondent comes from

Shumba	1	Maotsa	2
--------	---	--------	---

Date of interview	
-------------------	--

University Of Cape Town

Appendix I National Respondents' Statistics

Department	Number of Respondents	Females	Males
Central Statistics Office	1		1
Education, Sport and Culture	2	1	1
Health and Child Welfare	2	1	1
Local Government, Public Works and National Housing	2	1	1
Parliament of Zimbabwe	1		1
PTUZ	1		1
Social Welfare	1	1	
UNICEF	1	1	
ZIMSEC	2	1	1
ZIMTA	1	1	
NGO	2		2
Total	16	7	9

Source: Survey Data 2008.

Appendix J Maotsa Statistics on Respondents

Village	No of Households	Population	Number of Respondents	Females	Males	FGDs
Chikunguru	12	58	2	2	0	
Chikuni	11	55	2		2	
Chiweshe	10	56	2	1	1	
Gonese	58	278	3	1	2	
Kanongovere	39	157	2		2	
Kumbweya	24	118	2	1	1	
Madzivadondo	10	43	2	1	1	
Makanda	15	65	2		2	
Mamhinga	22	98	2	1	1	
Maotsa	48	240	3	1	2	1
Mashonganyika	5	21	2	1	1	
Masona	28	117	2	1	1	
Masvaya	23	178	2	1	1	
Matendewafa	10	63	2		2	1
Mudzimu	38	176	2		2	
Mugore	13	51	2	2	0	
Mukwasi	56	221	3	3	0	
Mupeta	58	185	2	1	1	
Musekiwa	17	113	2	2	0	
Mushipe	33	163	2	1	1	1
Nhamoinesu	35	178	2	1	1	
Sheche	29	135	2	1	1	
Shumba	14	57	2		2	
Ushe	18	77	2	2	0	1
Ward						
Total	626	2903	51	24	27	4
Key Informants			10	4	6	

Source: Survey Data 2008.

Appendix K Shumba Statistics on Respondents

Village	No of Households	Population	Number of Respondents	Females	Males	FGDs
Banga	30	155	2	1	1	
Banyure	59	320	3	2	1	
Chandaengerwa	43	163	2		2	
Chakuronda	64	180	2	1	1	
Chiroodza	46	111	2		2	
Dzawara	83	377	4	3	1	
Gaha	38	215	2	1	1	1
Guzha	33	187	2	1	1	
Madiro	37	158	2	1	1	
Mashinge	54	219	2	1	1	
Makamba	41	160	2	1	1	
Mazanhi	28	163	2	1	1	
Muchemeyi	50	220	2	1	1	
Munondo	68	315	3	1	2	
Mutanhaurwa	85	420	4	2	2	
Muunganirwa	48	201	2		2	
Nandu	101	617	4	2	2	
Ngwerume	65	310	3	1	2	
Pasipamire	58	330	3	2	1	
Ruzvidzo	23	100	2		2	
Shumba	84	500	4	2	2	1
Tamborenyoka	30	140	2	1	1	
Ward						5
Total	1168	5551	56	25	31	7
Key Informants			15	7	8	

Source: Survey Data 2008.

Appendix L Freedom House Country Scores for 2006

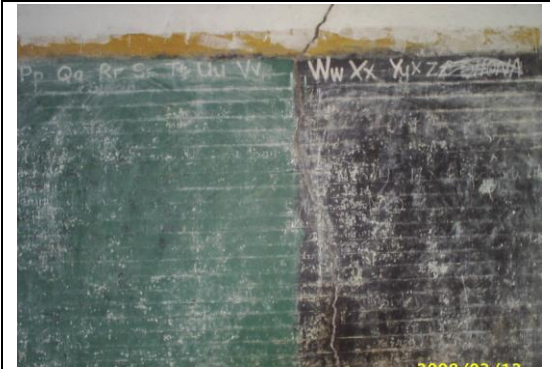
Country	Accountability and Public Voice	Civil Liberties	Rule of law	Anticorruption and transparency
Armenia	3.51	3.81	2.69	2.62
Azerbaijan	2.43	3.21	2.29	1.27
Bahrain	2.52	3.73	3.67	2.07
Cambodia	3.28	3.33	2.22	2.46
East Timor	3.83	4.64	3.81	2.62
Georgia	4.78	4.27	3.96	3.87
Guatemala	4.35	3.42	3.16	3.10
Guyana	4.53	4.76	4.79	3.99
Indonesia	4.70	3.70	2.97	2.45
Jordan	2.83	3.12	3.12	2.28
Kazakhstan	2.51	4.01	2.62	2.04
Kenya	5.16	4.58	3.90	3.24
Kyrgyzstan	4.17	4.17	3.38	2.54
Malawi	4.75	4.58	4.37	3.50
Malaysia	3.04	2.97	4.01	2.87
Morocco	3.30	3.67	3.04	2.14
Nepal	2.23	2.80	2.73	2.30
Nicaragua	4.49	4.20	3.61	3.40
Nigeria	3.51	3.34	2.90	2.51
Pakistan	2.15	1.76	1.83	2.14
Sierra Leone	4.65	4.15	3.78	3.17
South Africa	5.06	4.98	4.44	3.91
Sri Lanka	4.27	4.45	4.15	3.71
Tanzania	3.82	3.82	3.37	2.82
Uganda	3.99	3.81	3.66	3.74
Ukraine	4.85	4.34	3.65	3.01
Venezuela	3.00	4.07	2.98	2.13
Vietnam	1.63	3.00	2.75	2.61
Yemen	2.64	3.35	2.88	1.93
Zimbabwe	1.07	2.45	1.26	0.88

Key to scores:

- 0-2 Countries scoring between 0 and 2 ensure no or very few adequate protections, legal standards or rights in the rated category. Laws protecting the rights of citizens or the justice of the political process are nonexistent, rarely enforced, or routinely abused by authorities.
- 3-4 Countries with score of 3 and 4 provide few or very few protections, legal standards, or rights in the rated category. Legal protections are weak and enforcement of the law is inconsistent or corrupt.
- 5 Countries receiving a score of 5 provide some adequate protections, legal standards or rights in the rated category. Rights and political standards are protected, but enforcement may be unreliable and some abuses may occur.
- 6-7 Countries scoring 6 and 7 ensure nearly all adequate protections, legal standards, or rights in the rated category. Legal protections are strong and are usually enforced fairly. Citizens have access to legal redress when their rights are violated, and the political system functions smoothly.

Source: Tatic and Walker (2006, 3) *Countries at the Crossroads: A Survey of Democratic Governance*.

Education in Pictures



Dilapidated chalkboard in need of repair and cracks in wall at Mukwasi Primary School



Makeshift bench used by learners at Mtanhaurwa Primary School. Note there is no table and learners use their laps instead



Parents performing work in lieu of school fees at Mukwasi Primary School.



New classroom block being constructed by new responsible authority at Mtanhaurwa Primary School



Broken furniture at Mukwasi Primary School



Repair of classroom at Kanongovere Primary School undertaken by parents from community contributions and donated local labour

**‘STATE FAILURE’ IN PROVISION OF EDUCATION AND
HEALTH SERVICES IN ZIMBABWE: ADJUSTMENTS,
ADAPTATIONS AND EVOLVING COPING STRATEGIES OF
RURAL COMMUNITIES, 2000-2007.**

Thesis presented for the degree of

DOCTOR OF PHILOSOPHY

Department of Political Studies

UNIVERSITY OF CAPE TOWN

by

Norbert Musekiwa



Supervised by

Professor Robert Schrire



February 2010

Health in Pictures



Deep well servicing Shumba clinic



Community awareness meeting on health after reported case of cholera in Shumba in July 2007



The three roomed structure comprising the Shumba clinic.



Empty male ward at Maotsa clinic



Deserted entrance to a district hospital in Shumba during a typical industrial action



Respondents and researcher in middle. Note handling of toxic chemicals without protections and potential danger to health.

Methods in pictures



Focus Group Discussion with women in Shumba



Content analysis: Welcome board with names of school and village typifying the unresolved contest over ownership of the school.



Non-participant observation: Parents teachers meeting attended by researcher at MPS01



Community meeting addressed by local NGO and attended by researcher.



Observation; Ruling ZANU PF campaign graffiti superimposed on MDC's characterising the tension before the 2009 harmonised elections.



Focus Group Discussion with central government extension workers in Shumba