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Recreating Social Capital through nurturing *Ubuntu* in Community Health Clubs for disease prevention

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ABSTRACT

Whilst the concept of Social Capital is well known in Western literature as a measure of a functional community, the indigenous African ethical code known as *Ubuntu* is seldom referred to in community development programmes. We undertook exploratory research to better understand the extent to which values of *Ubuntu* are still recognised today and if such values could be co-opted into Community Health Club programmes to address the many common diseases that could be prevented by group action.

Method: A questionnaire was developed to identify key aspects of *Ubuntu* as lived experience in modern day Zimbabwe and how this ethic may manifest in the ordinary lives of Zimbabweans. The survey consisted of 40 questions with a mixture of quantifiable multiple-choice questions using a Lickert scale and qualitative open-ended questions. 100+ respondents were purposely selected representing a proportionate distribution of demographics. The quantitative data was cleaned and analysed in *Excel* with frequencies and percentages. The qualitative data was analysed using 'Applied Thematic Analysis'. A Focus Group Discussion with Shona and Ndebele community development officers was held to ensure a deeper cultural interpretation of findings.

Results: The ethical code of *Ubuntu* was understood by 95% of the 102 final respondents, who reported they had been brought up with such values. However, socialisation of children in norms and values of *Ubuntu* had dropped to 75% in the current generation of parents. Social networks in both rural and urban areas were high with all but 11% belonging to a regular group, and 45% having 21 or more friends within walking distance.

For the rural areas 64% of respondents considered '*Ubuntu*' to be high, 68% thought 'honesty' is high; 'child safety' in rural areas is considered *moderate* by 50% and *high* by 48% but only 9% would leave the door unlocked when going out. Only 4% could cite examples of non-*Ubuntu* behaviour in rural areas which included disrespect to elders, child disobedience, alcohol abuse, witchcraft and gender-based violence.

In urban areas, the inverse was found: only 16% thought there was any *Ubuntu at all*, and 81% thought there was *a high level* of non-*Ubuntu* behaviour, with a *low level* of 'honesty', no 'personal security' and low 'child safety'. 81% cited examples of erosion of *Ubuntu* values, such as lack of trust and reciprocity, substance abuse, little social support and immorality in sexual behaviour.

People who are guided by values of *Ubuntu* invest highly in community which may generate high social networks and reciprocity, although levels of trust still remain low. Unlike *Ubuntu*, 'Social Capital' is not an ethical code but is the 'common good' that may be the outcome if *Ubuntu* is practiced sufficiently by a large enough group.

Conclusion: *Ubuntu* is a living and valuable attribute of traditional Zimbabwean culture and could be resuscitated particularly in areas, where society is in transition from rural to urban lifestyle, to provide a secular code of ethics to promote gender equity and equality, through consensus building and preventing disease within Community Health Clubs, thereby addressing many ills of modern African society.

Keywords: Ubuntu, Unhu, Zimbabwe, Community Health Clubs, Social Capital, women's equality.

Introduction

The Determinants of Health

The Ottawa Charter defined 'Health Promotion' as *'the process of enabling people to increase control over and thereby improve their health'* (WHO, 1986).[1] In practical terms, however, exactly how *do* people exert control over their own health? To prevent the diseases such as respiratory infections, malnutrition, schistosomiasis, malaria, soil-transmitted helminth infections and trachoma, it is agreed that uncontaminated drinking water and safe sanitation are essential, but these facilities alone are not sufficient to prevent disease: safe home hygiene is a critical third component of any 'WASH' (Water, Sanitation *and* Hygiene) programme. Such an integrated approach requires the consistent cooperation of the women of the house, whose hygiene standards are usually the key to improving family health. In order to prevent diarrhoea in a community, it is now estimated that over 75% of the households must have safe sanitation and handwashing with soap must be routinely practised by the whole community at least after faecal contact: this relies on group action. Although water and sanitation facilities have increased in the past 20 years, by 2016, only 45% were estimated to have safe sanitation and only a quarter of people worldwide with access to handwashing facilities and soap.[2]

Health Care Services

Nor is it only the availability of a reliable health care facility that makes a difference to whether a child lives or dies but rather whether a health care facility is *valued* and is used sufficiently. For example, malaria accounts for over 400,000 people dying each year of which 370,000 were children in 2019[3]. Early treatment of malaria is critical for child survival but seeking treatment is contingent on a mother's information, understanding of the causes of disease, and her belief about prevention and treatment.[4] If she thinks that malaria is caused by sitting under mango trees, without realising that mosquitoes that transmit malaria hatch with the rains which is also the season that mangoes ripen, she will not understand the benefit of a mosquito net and will not adequately protect her child at night although she may prevent her child sitting under a mango tree. If she also belongs to an apostolic sect of Christianity that believes in prayer and not in modern medical treatment to save a child with fever, she will not seek treatment at a clinic. Her ability to resist her husband's refusal to let her seek treatment will depend on her self-efficacy (confidence to change)[5] as well as her faith in modern medicine. Our perspective is aligned with that of Social Epidemiology[6] in that in our opinion it is the underlying *values* of a community which determines whether they can as a group control a disease such as malaria which is an environmental health challenge.[7]

In highly developed Western societies, epitomised by the USA and Europe, health services have tended to approach public health challenges case-by-case, with individual need often trumping collective need. Well-resourced independent nuclear families with no extended family, and every chance of survival tend to have less concern and less concern for the common good. Treatment is a personal choice, and it is taken for granted that it is the responsibility of the state to provide a reasonable health service. The responsibility for the elderly, vulnerable and the infirm is seldom a priority in the self-serving nuclear family which is now

the norm in western society. The individual right to refuse vaccination at the expense of the society was recently demonstrated in the international response to control Covid 19 where it was considered an individual's right to choose whether to be vaccinated or not, even though universal vaccination was considered by experts to be the only way to control the pandemic.[8]

The opposite situation is found across vast rural areas of Africa, where government health systems seldom have the capacity to properly protect their citizens from fatal conditions and where the high mortality of women and children is often due to inadequate facilities. Because health services are too far apart or non-functional, people living at subsistence level, often have to rely on the collective support of their extended family and their community to survive, coping mechanisms have developed independent of the state. Such interdependency between people in need, has resulted in a survival strategy which places a high value on supporting collective need ahead of individual needs.

Ubuntu

This African ethic which can be found throughout the continent is now known internationally as *Ubuntu*, an indigenous code of conduct first publicised by the advocacy of Nelson Mandela. As the first democratically elected President of South Africa, he invoked *Ubuntu* to guide his nation in the newfound political freedom.[9] Archbishop Tutu, heading up the 'Truth and Reconciliation Commission' to heal the same divided country, called on *Ubuntu* to address the deep bitterness in a traumatised society by encouraging a return to a world view where interdependency between people is the ideal *"... the African concept of ubuntu is the essence of being human ... my humanity is caught up in yours. I am fully me only if you are all you can be."* [10] A Xhosa proverb from South Africa, says *'Umuntu, ngumuntu, ngabantu'* meaning that 'a person is a person through other persons.'[11] In Kenya the same concept is captured in the word *'Utu'*; in Malawi *'uMunthu'* means that a person on their own is nothing.[12] Similarly, the first woman President in Africa, Ellen Johnson Sirleaf, reactivated the concept of *'Measuagoon'* after the civil war in Liberia, meaning 'We are one' in the Gola language. She writes, *"In Africa the debate between Western Individualism and African collectivism rages on. Some call for a return, in Africa, to the concept of 'ubuntu' - a Bantu word that expresses the concept of the traditional African value system of collectivism, of emphasising the communal good over individual desires and needs."* As the first President of Tanzania Julius Nyerere, is said to have quipped, '*In Africa, we sit under a tree until we agree.'*

In Zimbabwe *Ubuntu* is known as *'Unhu'* and as described by Gelfand it is *'a good and moral ideal.*' A person with an unselfish personality is known as *Munhu* and is highly respected as representing the best of values in Shona Society. *'Unhu is derived from parents, from tribal practices and inheritance from the distant past.'* [13] In a time of crisis when the HIV/AIDS pandemic was destroying African society the ethic of *Ubuntu* came to the fore, and families adopt children whose parents had died. '*Children are never orphans since the roles of mother and father are by definition, not vested only in a single individual with respect to a single child. Furthermore, a man or a woman with "unhu" will never allow any child around him to be an orphan.'* [14].

Regarding human rights, however some have raised legitimate concerns that *Unhu* as received from previous generations has justified gender inequality. For example, traditionally only men can own land thus disempowering women who are unmarried or widowed. There are some aspects which clash with modern living which may also undermine women's dignity and *Unhu* should not therefore be considered a panacea for all societal ills.[15]

The Community Health Club Approach

With the perceived need to create more opportunity for communities to self-organise in order to prevent high infant and maternal mortality in Zimbabwe, a new methodology was developed gathering households to join Community Health Clubs (CHCs). This was a consensual method of health promotion, to build 'Common Unity', enabling women, in particular, to be sufficiently informed and organised to control the determinants of health through working together.[16] On the basis of a successful field trial, an indigenous Non-Governmental Organisation (NGO), called Zimbabwe AHEAD was formed in 1995, to replicate the new CHC approach in three districts. Within a year 265 CHCs had been started in Makoni district with 11,450 members, 85 in Gutu with 4,845 members, and 32 in Tsholotsho district with 2,105 members. Tsholotsho achieved the highest rate of behaviour change as shown in spot observations of a random sample, which showed 92% safe sanitation in CHC households (43% with latrines and 57% practising faecal burial) as compared to 2% in the control, with safe handwashing practiced in 91% of CHC homes compared to 3% in the control ($p>0.001$). The difference in 21 observations between intervention and control ranged from 70% to 27%, an achievement which was much higher than another innovative approach known as Social Marketing which was being implemented concurrently in Burkina Faso that focused narrowly on only 4 indicators and which achieved a range between 9% and 17% difference.[17]

Based on this evidence of strong hygiene behaviour change at minimal cost of under USD5 per person, the CHC approach was scaled up in Zimbabwe and by 2023 it is estimated that over a million people had been reached through 3,557 Community Health Clubs being started just by our organisation, now known as Africa AHEAD *(See Table 1. below)*[18]. After the National Water Policy (2012)[19] and National Sanitation and Hygiene Strategy (2017)[20] made the CHC approach mandatory for Zimbabwe, most NGOs began to use the classic CHC training in similar Water, Sanitation and Hygiene (WASH) projects. In the last decade urban CHCs have also been successful in building a supportive urban environment in most small towns as documented in recent large-scale programme[21] in over 500 Community Health Clubs where CHC members raised money to build all members a latrine.

The Community Health Club (CHC) methodology is now well established as an effective hygiene behaviour change methodology in the WASH Sector having been replicated in 12 African countries. Through our training of other partners an additional 1,235 CHCs have been started with an estimated 77,182 CHC members in projects outside Zimbabwe (*See Table 1, below).*

Table 1: Number of Community Health Clubs started by Africa AHEAD and partners (1995-2022)[18]

1995-2022				
Start up	CHC Countries	CHC	Members	Beneficiaries
1995	Zimbabwe	3,557	233,344	1,166,720
2002	Sierra Leone	50	4,000	24,000
2003	Uganda	200	1,600	96,000
2004	South Africa	350	28,000	168,000
2007	Guinea Bissau	200	16,000	96,000
2010	Rwanda	150	9,924	49,620
2010	Tanzania	193	9,440	56,000
2011	Namibia	3	300	2,770
2015	DRC	20	1,600	9,600
2021	Kenya	48	4,560	21,000
2021	Malawi	17	1,578	6,985
2022	South Sudan	4	180	900
	TOTAL by AA / Partners	4,792	310,526	1,697,595
	Rwanda National Program	14,000	700,000	3,500,000
2022	Total CHC recorded in Africa	18,792	1,010,526	5,197,595

All these projects were relatively small scale compared to the programmes in Zimbabwe but demonstrated as seed projects how CHCs can be used in different contexts: in Sierra Leone with CARE International for post conflict rehabilitation,[22] and in refugee camps in Uganda,[23] in South Africa through Ministry of Water for rural villages[24] and in city municipalities for clean-up campaigns.[25] In a large Randomised Control Trial CHCs were started in 200 Muslem villages in Guinea Bissau to encourage use of health services.[26] In Namibia CHCs were used for the management of urban ablution blocks in informal settlements,[27] and in Democratic Republic of Congo for civil reconstruction.[28] In 2010, our advocacy resulted in the CHC approach being adopted by the Ministry of Health in a national programme throughout Rwanda[29] in over 14,000 villages, reaching an estimated 3.5 million people, demonstrating substantial community response nationwide. Behaviour change took longer than expected but three years after the end of a Randomised Control Trial was complete in one district of Rusizi, levels of behaviour change were found to be comparable to Zimbabwean levels,[30] with a study finding indications of reduction of hygiene related diseases and malnutrition.[31] In Burkina Faso, a small research project has resulted in the CHC methodology being adopted into national policy.[32] With the advent of Covid 19, and the inability to train in the field, Africa AHEAD Association has trained five NGOs online to start small pilot projects in Malawi, South Sudan, Kenya and Tanzania.[33] Outside Africa, Community Health Clubs have been started in Vietnam showing significant reduction in diarrhoea,[34] and in the Caribbean, firstly in the Dominican Republic[35] and then in Haiti.[36] The first Community Health Clubs in America,

are being piloted with Hispanic communities on the Texas Mexican border to address a number of urban challenges such as mental health, substance abuse, early teenage pregnancy and gender-based violence.[37]

The United Nations Sustainable Development Goals (SDGs)

Although to-date most Community Health Clubs have been started in the WASH Sector to achieve safe water and sanitation for all (SDG6), the same CHCs can also be used to address SDG targets in other sectors including: working towards eliminating absolute **poverty** (SGD 1) and **hunger** within a community (SDG 2); ensuring **health** and well-being by enabling people to prevent common diseases by good hygiene (SDG 3); enabling girls achieve the same **education** (SD4) as boys by addressing **gender equity** (SDG 5) in schools due to menstruation and early pregnancy; promoting local **climate action** (SDG 8) by reafforestation, prevention of soil erosion and the use of fuel efficient stoves to save **energy** (SDG 7), as well as proving **income** locally for women through training in new skills (STG 13).[38]

Social Capital

The term 'Social Capital' was first coined in the sociological literature in 1916 by Hannifan,[39] who wrote a broad definition: *'social capital is anything that facilitates individual or collective action, generated by networks of relationships, reciprocity, trust, and social norms.'* By the 1970's, the lack of social cohesion in America as a result of urbanisation and modernisation became noticeable and as individualism rather than communal world view became the norm, social capital diminished.[40]

Developing countries are today facing the same dilemma as America of the 1970's as education level increases and farmers aspire to employment in towns. In the past 40 years since 1982, literacy in Zimbabwe has increased from 77.7% to 89.9% in 2022, and is now the highest in Africa.[41] It is reasonable to assume that African societies will suffer from the same anomie as was identified in America as countries became industrialised and lose their rural values as the urban drift undermines traditional values. Modern Africans are also facing similar lifestyle diseases which have been found in industrialised countries and would benefit from increased 'social capital' as it appears many physical and mental disorders in America are less prevalent in areas of higher social networks.[42]

Community Health Clubs

Community Health Clubs can be said to generate 'social capital' in that a CHC usually provides a forum for a community to come together to manage public health issues of an area that will benefit not only those in the CHC but the larger community. As such, we have in past papers liberally described the CHC approach as one which is capable of generating 'social capital' in a positive sense. The 'Classic' Community Health Club normally aims to engage at least 80%, if not all of the households in a geographical area using positive peer pressure to develop 'common unity' through the values of healthy living and reciprocity which engender a 'culture of health.' The CHC weekly meetings provide an opportunity for every household to work together for the common good. Research shows that if the classic CHC 'recipe' is followed the programme can be expected to result in the majority of households practising a raft of 50 good hygiene practices[43] which are known to control diarrhoea, cholera, malaria, bilharzia, skin diseases, worms, pneumonia, as well as

address malnutrition and prevent premature deaths of children under 5 years from such preventable diseases.[44] A recent review of literature of the WASH Sector has found ten studies of Community Health Club programmes which also mention, in addition to WASH behaviour change, some form of collective action for the health of the larger society.[45]

However, there is a wide range of community response from high to minimal and high levels of 'social capital' are not always apparent in CHCs as for example, in the slums of Haiti which were below expectation. Rosenfeld suggests that a high level of hygiene behaviour change maybe contingent on a certain pre-existing level of Social Capital.[46] The level of 'trust' is also the focus of another small but interesting study from Rwanda which analysed the determinants which may account for differences between a 'high-performing' and a 'low-performing' CHC in terms of hygiene behaviour change.[47] Ntakarutimana finds that high levels of 'buy-in' by the community and hence behaviour change, are associated with a higher level of 'trust' that exists in a village. In this paper we therefore hope to clarify the terminology to be used in future research.

Research Questions

None of the literature on CHC has yet explicitly identified how indicators of Social Capital found in America,[48] such as increased social networks, trust and reciprocity which are now identified in Community Health Clubs in Africa, may be confounded by indicators of pre-existing *Ubuntu*. We need to understand if *Ubuntu* is an African equivalent of the American concept of Social Capital.

In this paper we seek to ascertain firstly, if *Ubuntu* still guides behaviour in the younger generation in Zimbabwe and if any different from the previous generation; secondly, if *Ubuntu* is still an operational value system both in the rural and urban areas of modern-day Zimbabwe. Thirdly, if *Unhu* is still extant, is it a trigger which can promote community health within a framework of gender equality and equity. Lastly should we be applying the term Social Capital to programmes in Africa that generate community action and mutual support when these positive outcomes may more correctly be attributed to *Ubuntu*.

Zimbabwe was chosen for convenience because it is where Africa AHEAD (AA), the organisation which first started CHCs is based and where thousands of CHCs have been successful as described in five peer reviewed papers mentioned above.[16 21 30 34 43]

Limitations and possible bias:

Limitations of this study are that Zimbabwean society may not represent the norm of *Ubuntu* in Africa, which will obviously vary between countries and according to context, so we cannot generalise about *Ubuntu* in Africa without further study. It could be argued that as our team are leading experts of the CHC approach, some enumerator bias is possible in the interpretation. However, we are not reporting on our own work as such, as our interest is to understand the phenomenon of *Ubuntu*. As we are not at this stage, correlating levels of *Ubuntu* with response in terms of group behaviour change, such enumerator bias is unlikely. This paper reports only exploratory research to establish definitions of indicators, which may inform an experimental design which will control for such bias, with more sophisticated statistical analysis.

Method

This paper aims to garner some basic understanding on how *Ubuntu* is perceived by Zimbabweans for more in depth future research using a mixture of quantitative and qualitative methods. To avoid confusion, we *use* the generic term of *Ubuntu* for all countries, whilst we use the Zimbabwean term *Unhu* when referring to *Ubuntu* in Zimbabwe.

Survey tool: A questionnaire was developed by the team to identify key aspects of *Ubuntu* as lived experience in modern day Zimbabwe and how this ethic may manifest in the ordinary lives of the working Zimbabweans. The survey consisted of 40 questions with a mixture of quantitative questions using Lickert scale multiple response options and some questions in which qualitative open-ended answers were solicited. Africa AHEAD project officers were the enumerators, all with many years of experience in Community Health Clubs as well as a master's degree. They were trained online and were first asked to pre-test the survey by self-administration of the online survey, in order to test their own understanding of the questions. Some adjustments and additions were made to improve any ambiguous questions and ensure all enumerators were using the same definitions and same standards. The questionnaire was asked verbally in English, but responses were received in Shona, Ndebele and English. They were simultaneously translated into English on the survey by the enumerators who all had a high standard of English, Shona and Ndebele and keyed into the cell phone survey.

Sampling: Over one hundred respondents were purposely selected by each enumerator to enable a balanced spread of demographic variables to obtain a proportionately representative sample of the target population in terms of gender, age, social status by occupation, education, and rural or urban lifestyles as well as a proportionate sample of the two main ethnic groups in Zimbabwe: the Shona (70%) and Ndebele (20%) in a population of 15 million (2022). There was no one geographic location of the survey as respondents were convenience sampled based on their availability and interest to participate.

Data collection: The quantitate answers were collated automatically online using the mWater Surveyor, a mobile Ap for data collection. The results were then viewed graphically on the mWater portal for the preliminary results. The data was downloaded into *Excel* and any incomplete surveys with anomalies were removed by the author and the data cleaned leaving 102 respondents with no missed questions.

Analysis: The quantitative data was analysed with frequencies and percentages presented in bar graphs and pie charts enabled visualisation of patterns in the data to inform the Focus Group Discussion. The qualitative data was analysed by the author using 'Applied Thematic Analysis', as described by Guest, MacQueen and Namey.[49] This is a practical framework with which to identify codes for categories of answers and by inductive enquiry, a summary of the qualitative responses of open-ended answers was drawn from the survey and coded according to categories.

Respondents' data privacy: All respondents were asked if their personal data could be used for publication, and only those who did not object to being quoted *verbatim* have been included in this paper.

The findings were then reviewed by 10 key informants in a Focus Group Discussion by experienced professionals with a Shona or Ndebele upbringing and a master's degree in development. They provided more in-depth explanations and cultural understanding of some of the findings, to the author who is an English-speaking Zimbabwean.

Results

Profile of the respondents: In total there were 102 respondents of which 74% were Shona speaking and 19% were Ndebele with 7% respondents from minority ethnic groups (Kalanga, Venda, Tonga, Setswana, and Malawian). All respondents but one, were fluent in Shona. There were 49% male and 51% women respondents. Age was well distributed equally across all cohorts with 55% being under 40. Average level of education was high with 17% having tertiary diploma and 43% of respondents having one or more degrees. *(See Table 2. below).*

Table 2. Demographic description of the Respondents

Demography of Respondents			*n*=102
Mother Tongue	%	Occupation n=90	%
Shona	74%	Volunteers	2%
Ndebele	19%	Students / underage	**7%**
Other	7%	Housewives	**3%**
Gender		Unemployed	**12%**
Female	51%	Unskilled workers	**5%**
Male	49%	Artisans	**6%**
Other	0%	Self-employed	**8%**
Age		Farmers	**11%**
15-18 years	9%	Low professional	**10%**
19-21 years	7%	High professional	**16%**
22-29 years	18%	**AA staff**	**20%**
30-39 years	21%	Formal education	
40-49 years	21%	Only primary	14%
50-59 years	21%	Secondary & primary	26%
60-69 years	2%	Tertiary certificate/diploma	17%
70- 89 years	1%	One or more Degrees	43%

Understanding of the Concept of Unhu: Of 102 respondents, 93% easily understood the word *Unhu*, selecting correctly either one of different versions of the concept; only 6 respondents opted for the wrong answer. All respondents except nine thought *Unhu* was the same as *Ubuntu*, whilst three spelt *Unhu* as *Hunhu*. A Malawian called it *uMunthu,* a Venda called it *Buthu*, Ndebele and Kalanga called it *Ubuntu*, and Setswana *Buntu*. Sixteen respondents added that *Unhu* in English meant *'good behaviour'*. 95% of respondents said that their '*parents were very strong on Ubuntu*.' 25 of this group said that they themselves did not bring up their own children with the *Ubuntu* ethnic, whilst the five

who did not grow up with *Ubuntu* also did not bring up their own children by the *Ubuntu* ethic. From this small sample we calculate a 20% drop in the traditional *Ubuntu* upbringing within a generation from 95% to 75% in Zimbabwe.

A deeper understanding of *Ubuntu* was solicited by the question: '*Give a short example of what you would say to your child, or what your mother said to you.'* The following are the main themes which emerged with one example of each quality quoted below: intergenerational respect, social connectivity, unselfishness, kindness, charity, right behaviour (politeness), honesty, integrity, humility, and social equality, modesty, good manners, as well as being law-abiding and having self-respect. *(See Table 3. below*)

Gender Equality: We combed the survey answers for indications of gender inequity from the respondents but there were few mentioned in connection with *Unhu*. Only one example of a role model of *Unhu* depicted women's subservience to men,
"My aunt, she used to greet men whilst on her knees rather than standing. She called her husband 'shewe' translated to 'my lord.' She could listen to her husband's commands without compromising."

However, in answer to the question: *"Are boys and girls, men and women equal within the culture of Unhu?"* 51% of respondents interpreted the question to mean, 'are the genders equal within the current situation in Zimbabwean culture' and they were very clear that in practical terms men and women in modern day Zimbabwe are not at treated equally, nor do they have the same chances in life.

- *'Men and boys usually have the lion's share of everything,'*
- *'Men are always the leaders,'*
- *'Males are more superior than females.'*
- *'No! there is a 150-year gap to reach equality.'*
- *'Boys are liked more and respected more.'*

However, 50 people (of which 28 were women) interpreted the question as their own opinion of gender equality, and according to them *"Yes, we are all equal and we should be given the same chances,*' and *"Men take the lead, but everyone is equal."*

***Unhu* Role Models:** When asked if they knew of a role model of *Unhu*, most respondents could immediately think of someone they knew: four gave examples of people who were not snobbish although they were better off than their neighbours; fifteen respondents cited charitable people they know in their community who help others. Twenty-two people cited their parents or family members as a role model of Unhu, as this respondent,

"My mother is my definition of unhu. She is that kind of person called 'person of people ' ***munhu wevanhu'*** *in Shona. She always shares the little she has with others in our area even if she has little. She is known by that character in our community."*

Mandela was the only public figure cited as a role model of *Unhu*, mentioned twice*:*

- *'Mandela was the only person who had high resemblance of Unhu...'*
- *'He (Mandela) put the nation first before himself and led the country with much wisdom.'*

Table 3: Respondents examples of the qualities of Unhu that should be taught to children.

QUALITIES OF UNHU THAT CHILDREN SHOULD BE TAUGHT
• Intergenerational Respect: *If you see someone of parents age, you must treat them as your parents. Even if they are not your biological parents, accept their rebuke because you are everyone's child, and it takes a village to raise a child.* • Interbeing / social connectivity: *My children, as I always say to you, when growing up, you don't grow for yourself but for others as well. Remember in life you need others to be whatever you are.* • Unselfishness: *I encourage you my children to always consider the needs of everyone around you and have a spirit of servitude. Don't take everything. Think about the others, don't be selfish. Of the fruits in an orchard or in the wild, only pick only what is enough and leave the rest for others to pick as well.* • Kindness: *My children, nothing in this life is permanent and life is a wheel so do not laugh at others when misfortunes befall them but instead empathise with them.* • Charity: *We are given blessings so we can share them with others, also blessing them and making their lives better. Give visitors available food and after eating, they will appreciate it.* • Modesty: *Dress in descent attire that you will not feel shy even when you are in a crowd of people.* • Manners: *Don't talk while eating. Like everyone you should sit down when eating. Show respect when serving food to people.* • Right Behaviour / politeness: *Keeping quiet at times can prevent you from getting in trouble; speak calmly, be polite with others, wherever you are and wherever you go. Do not to talk back when being corrected. Respect and listen to other people when they talk.* • Honesty/ Integrity: *Be trustworthy, don't lie and do not steal. What is wrong is wrong, no matter how much people try to justify. Always do what is good and don't follow the crowd.* • Law abiding: *Just say no to theft, laziness and loose behaviour. Ensure that you do things that are acceptable by the law, society and with integrity which also conforms to human values.* • Self-respect: *Respect yourself. Be the person everyone would wish to have, not to be the spit of the village.* • Humility: *Be humble and seek for forgiveness where you make mistakes. I encourage you to apologize even you feel you are right. There is no saint in this life, so never judge people. Be humble. Value everyone.* • *Equality:* *Treat everyone with respect and dignity no matter their social status, culture or religion. You should know that all human beings are the same despite different creed or culture so treat others how you treat yourself. Don't look down on anyone, you will definitely need them at some point."*

Confounding: As many of the attributes of good *Unhu* correspond to Christian virtues, there could have been some confounding. However, we found it relevant that only two respondents said that their *Unhu* 'role model', was also a practicing Christian. Given that Zimbabwe is a highly Christian country, more probing could have been done on the impact of Christianity on traditional ethics and we neglected to collect demographic data on respondent's religious affiliation. Three respondents noted that in the town, charity through church groups and through Rotary was similar to traditional *Ubuntu*. More thorough and far-reaching research needs to be done with accurate sampling to explore details of our findings more thoroughly.

***Unhu* in Urban areas:** Of 102 respondents 27% said adamantly the *Unhu* was **non-existent** in town, 35% said it was **much less than before**, 10% felt there was **a bit** of *unhu*; 16% respondents cited **some** evidence of *Unhu* in the town, for example, elders given places in the bus or in long queues, people helping at funerals; 5% had never been to town and 7% did not respond. More inciteful responses are quoted as follows:

- *"Ubuntu got eroded by western and useless culture that does not safeguard our culture of Ubuntu."*
- *"In urban areas, Unhu is very limited as there are mixed people with mixed cultures, values and norms."*
- *"Not much, but there are community groups called **ozibuthe** who help in the event of a bereavement or illness through home visits, financial and material contributions."*

81% of respondents cited *non-Unhu* behaviour such as the following:

Erosion of traditional customs:

- *"Lack of Unhu is rife... when one wants to marry, they do not seek consent of parents they can take strangers or friends and witness their marriage vows in court,"*
- *"People mind their own business, no respect especially for the elders."*

Lack of social cohesion:

- *"Some community members don't even know their immediate neighbours let alone participate in community engagements such as funerals."*

Lack of social support:

- *"I have a friend who says his house was broken into a few weeks ago and when he called out to the neighbours for help no one came. But when he saw them the following morning, they confirmed they heard his cries for help but did not want to risk rushing in. People only do what they don't think will inconvenience them."*

Moral outrage at the lack of decent behaviour in town with horror stories:

- *'There is more of incest, and there is the LGBQTIA community that prefer same sex, there are sex workers unions,"*
- *"vuzu parties where teenagers book houses for the weekend and have sex competitions with each other in the*
- *Same room for the whole weekend."*
- *"At funerals they do sex dances and blow condoms,"*

[1] LGBTIQ+ is an evolving acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual. Many other terms (such as non-binary and pansexual) that people use to describe their experiences of their gender, sexuality and physiological sex characteristics.

Table 3: Perceived levels of Unhu and non-Unhu behaviour, trust, personal security, and child safety in rural and urban areas of Zimbabwe.

		Rural areas/ Village		Urban areas / Town	
Unhu		*n* = 45	%	*n* = 100	%
in practice	Negative behaviour	3	7	81	81
	Positive behaviour	42	64	16	16
Level of Trust	Neighbours' honesty	*n* =44	%	*n* = 38	%
Low	Low honesty	3	7	9	24
Moderate	Partial honesty	11	25	21	55
High	Complete honesty	30	68	3	8
Personal Security	Door locked	*n* =44	%	*n* = 39	%
Low	All the time	3	9	18	46
Moderate	Only when out	22	50	19	49
High	Never lock	4	9	0	0
Child safety	Allowed out	*n* =42	%	*n* = 36	%
Low	Never out alone	1	2	18	50
Moderate	Play in street	21	50	14	39
High	Go anywhere	20	48	3	8

"There is a lot of foreign cultures which do not conform with our societal culture and values, a lot of theft, drug abuse leading to obscenities, abortions, unacceptable dressing."

***Unhu* in the rural areas:** 64% of respondents found little evidence of *non-unhu* behaviour in the rural areas; 4% gave examples of non-*unhu* behaviour such as abusive language, disobedience, alcoholism, drug taking, witchcraft, and theft whilst 7% cited more serious criminal offenses such as child marriage, gender-based violence, rape, theft of land and abuse of widows; 12% did not give any response, and 3% were non-committal.

Most believe that *Unhu* is active in a positive way describing an idyllic society as the composite response below indicates.

- *'We are one in rural areas as we do things in harmony and in common unity.'*
- *'Community members respect each other and help one another in difficult times.'*
- *'Children greet elders and respect them by not speaking slang near them and respect them as their parents.'*
- *'They also assist elders in day-to-day duties.'*
- *'In old rural areas, young people always fetch water for the old people; they also make sure that they assist old people in any kind of work.' 'People with chronic illnesses are helped by others to fetch firewood and water.'*
- *'In rural communities people freely help each other without any charge.'*
- *'There is a strong bond of Unhu in rural areas as they are able to understand each other, social cohesion, common unity that they abide with.'*

- *'In rural areas each and every person is obligated to adhere to unhu be it in talking, behaviour, socialising.'*
- *'People in rural areas have a social unity and most of them if not all have the unique characteristics of unhu. All age groups have same traits of unhu, despite age or religion.'*

Social networks: People in both town and country are highly networked and have a large number of friends within walking distance. Of 102 respondents, 45% knew 21+ people, 8% knew 16-20 people, 12% knew 11-15 people, 15% know 6-10 people, 20% knew 1-5 people, and not one person knew absolutely no one within walking distance. Of 88 respondents, all but 11% belonged to one or more group that met regularly: 62 belonged to religious groups, 20 to sports groups, 15 to farmers groups, 10 to a hobby club, 11 to others not specified and 4 to a Parents Teachers Association. 13 respondents belonged to a Community Health Club.

Reciprocity and Social Support: The term 'Social Capital' was only understood by 10% of respondents who were not AA employees. 19% of those that did not know, guessed Social Capital was to do with financial investment in social causes. Although the term 'Social Capital' was not known by respondents, they cited many indicators of what could be called 'Social Capital.' In an emergency there is a high level of reciprocity in terms of social support in Zimbabwe as all the respondents had some support: 13 would go to the community, 30 would go to family and 34 would go to friends. For the purposes of this research, it is interesting to compare support of a church group and a community health club: five CHC members out of 13 would go to their CHC (38%), whilst only 10 out of 62 in a church group would go to their church for help (16%). This in itself validates the role of a CHC as a secular community safety net.

Perceived Trust: There is a highly significant correlation between the level of perceived trust as well as perceived *Unhu* related to rural and urban area as shown in Table 2. Above. Living conditions in rural areas are considered high in '*Unhu'* by 64% with 68% thinking 'honesty' is high, and 'child safety' moderate (50%) to high (48%) although only 9% never lock the door. The inverse is perceived in urban areas where only 16% thought there was any '*Unhu'* and 81% thought there was a high level of '*non unhu* 'behaviour, low level of 'honesty', no 'personal security' and low 'child safety'.

Discussion

Terminology: This research has clarified our terminology and definitions. We suggest that *Ubuntu* should not be confused with Social Capital as identified in Western academic literature and the two terms should not be used interchangeably. The term 'Social Capital' as described by most academics[34] refers to the density of social networks which are believed to affect levels of trust and reciprocity, i.e., the social connectivity within the neighbourhood. However, the word 'Capital' is not understood as a positive attribute in post-independent Africa as it carries an association with 'Capitalism' which is often seen as foreigner's profiting to the detriment of the continent. 'Social capital' is thus subconsciously associated with some form of exploitation of people, or if positively interpreted as a monetary fund to support social causes, neither of which are correct.

By contrast *Unhu,* is understood by respondents to be a highly positive term,

identical to the South Africa ethic of *Ubuntu* which is much admired throughout Africa. As the terms *Ubuntu* and *Unhu* are well understood by modern Zimbabweans, in both the younger (under 30) and the older generation, how much better to use indigenous grass roots terminology to interpret community dynamics in Africa.

Ubuntu is an African world view which sees the highest value of life when the individual person is part of the intricate fabric of society. This comportment of someone with *Unhu* is comparable with standard religious values with respect, humility, kindness, and generosity being highly respected. Unlike Christianity, which was imported from abroad, *Ubuntu* is a secular value system which has been handed down from a pre-colonial era of the African continent before some of the traditional values were eroded by modernisation and a different moral code of behaviour. As an indigenous ethical system *Ubuntu* is today highly prized because it brings dignity to a new generation of liberated Africans seeking to validate their own culture in the aftermath of colonial domination. As such *Ubuntu* may provide an alternative narrative in Community Health Club development programmes which to date have used the American term 'Social Capital' to explain group dynamics. Explaining achievement in CHCs as 'Social Capital' is to impose a foreign value system by the use of imported terminology which may confound findings in an African context.

Social Capital or *Ubuntu*?

The 'social capital' we have often claimed that is developed within CHCs, may in fact be residual cultural traits of *Ubuntu* unwittingly resurrected by the consensual activities in Community Health Clubs. Much of the communal spirit witnessed in CHCs might be due to inherent levels of *Ubuntu* which have not been identified at base line. It is important to conduct a base line survey with indicators that make a clear distinction between Social Capitalism and *Ubuntu*.

If some natural *Ubuntu* already exists in a project area, CHCs may be easier to set up and more successful in their outcomes, as identified by Ntakarutimana. As such 'social capital' may be an *outcome* of *Ubuntu*, not the *cause* of *Ubuntu. This* may explain why Haitian CHCs may not have succeeded as well as in Zimbabwe where *Ubuntu* is still an operative value, but only more research can support such a hypothesis.

How to nurture *Ubuntu*

If we believe that some level of Social Capital is needed to achieve group behaviour change, it follows that we need firstly to foster the values of *Ubuntu/Unhu.* We can develop *Ubuntu* by explicitly promoting mutual respect, trust and reciprocity within a Community Health Club. We have been doing this unwittingly, calling it 'Common-Unity' i.e., a fully functional group able to manage the determinants of health and well-being - our definition of a 'real Community' with a capital 'C'.

Whilst this research provides anecdotal evidence that *Unhu* is waning in the urban areas, it is not too late to resurrect many positive aspects of local culture in terms of social support to the individual *(Unhu)* as identified by Gelfand[13] in the 1970's, as the values have not disappeared entirely in current Zimbabwean culture. However, development practitioners should not now seize on *Ubuntu*

like a magic bullet to fix all challenges of community development. Neither should *Ubuntu* be imposed by outsiders, in a neo-colonial or patriarchal way. *Ubuntu* can only be transferred by resurrecting and nurturing existing norms from within the society, by highlighting examples of *Ubuntu* and building on good ethical behaviour. The 'participatory methodology' already in use in Community Health Clubs is thus an ideal vehicle to resuscitate strong communal values transferred by song and drama, as a lived reality in Africa. As well as national heroes such as Nelson Mandela and Archbishop Tutu of the older generation, we need to find new role models to inspire the younger generation (such as renowned social commentator Trevor Noah and Springbok Captain Siya Kolisi to inspire a return to *Ubuntu* in this era.

Group Dynamics

This tension between the values that sustain the status quo and those that allow progress, can be overcome by coopting *Ubuntu* in a Community Health Club in the same way that conflicts were traditionally settled in the village, by dialogue until there is consensus. It may take longer to achieve than the more top-down imposition of ideas, but when the change is endorsed by the whole group, peer pressure to conform dictates behaviour for all. Participatory activities that are done in dialogue sessions in Community Health Clubs enable everyone to agree to adopt a new change together, without fear of retribution for being different or progressive. This consensus approach chimes with the ideal of *Unhu/Ubuntu* which puts community before individual gain.

Urban *Ubuntu* for Youth

Do we give up on the idea of Community Health Clubs in neighbourhoods with little or no *Ubuntu*? Can we neglect areas where the youth are alienated and unemployed and where absolute poverty necessitates lawlessness for survival, where trust is low and substance abuse is endemic? No, as community developers we can resurrect traditional values of communality which may have been lost in the individualistic urban lifestyle, in much the same way the Christian values are instilled in Sunday school, by weekly meeting and group activities. This socialisation of the youth in *Ubuntu* may take time, but it is the foundation on which to build positive change for the future within the health sector. With very low levels of trust in urban areas, there is an identifiable need for a secular group such as an *Ubuntu* Club to build cooperation between urban dwellers, focusing on urban youth, providing training in life skills that promote inter connectivity. 'I am only well, if you are well'. This approach may be used within a modern lifestyle to counter drug and alcohol abuse, gender-based violence, sexually transmitted diseases and non-risk sexual behaviour, gender identity and avert child marriages and early pregnancy.

Gender Equity and Ubuntu

There are clearly aspects of conservative culture in Africa that result in women being kept in a subservient position. The norms and values of *Ubuntu* were handed down orally through stories and sayings from a pre-literate era when women were assigned an inferior role in many African cultures. Women were taught to approach men and serve food on their knees. Whilst few practice this now the mentality of women as second-class citizens is still the norm, and women find it difficult to get into leadership positions. Therefore, *Ubuntu* cannot be enshrined as a perfect set

of values but as a 'work in process' redefined by each generation according to the challenges of the times. However, some customs are incompatible with modern living where gender equity and equality are now expected. CHCs today should seek to recreate *Unhu* in a more modern paradigm to ensure women's dignity is protected.

The Community Health Club should provide a forum not just for women but also seek a gender balance with more men providing an opportunity to work together to overcome the challenges they face as a family. A 'womanist' perspective does not seek to overthrow male leadership as does the more assertive form of feminism. In common with *Ubuntu,* 'womanism' aims for '*the survival and wholeness of the entire people, male and female*' with equal dignity and opportunities for all.[15] This balance between genders is a vital means to assert full control over the determinants of health. Such equity is in line with the very heart of the *Ubuntu* paradigm, as male and female cannot prosper in isolation, nor can the family thrive as well without the full cooperation of both father and mother. The *Ubuntu* creed, *'I am because you are'* is in fact the key to ensuring public health.

Trust and Reciprocity

In the usual literature on Social Capital, the words 'trust and reciprocity' are frequently mentioned as if they operate in tandem, augmenting each other: more reciprocity is assumed to be associated with higher levels of trust. In Zimbabwe (and presumably other African countries) the concept of 'Trust' needs to be more carefully defined before it is used as an indicator. Does 'Trust' imply a confidence that a person will do you no harm, or does it mean basic honesty in terms of lack of theft of goods? In this research we have identified an anomaly concerning *Ubuntu* which needs more discussion. The rural areas of Zimbabwe appear high in *Ubuntu* with correspondingly high levels of 'reciprocity', which would be expected. However, it is curious that this high level of 'reciprocity' (the exchange of favours) does not result in high levels of 'trust' (in terms of honesty, personal safety of women, children, and belongings). How can this lack of 'trust' be explained? Levels of trust may be associated with levels of wealth rather than being a general indicator of 'social capital'. New indicators need to be developed for *Ubuntu* as a substitute for those routinely used when describing Social Capital.

Conclusion

Ubuntu is a living and valuable attribute of traditional Zimbabwean culture and could be resuscitated particularly in areas, where society is in transition from rural to urban lifestyle, to provide a secular code of ethics to promote gender equity and equality, through consensus building and preventing disease within Community Health Clubs, thereby addressing many ills of modern African society.

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