Chapter 9: Towards Policy and Practical Models to Inform Governance of Urban Health in Zimbabwe

The study explored population distribution, health facilities and epidemiological patterns: towards policy and practical models to inform governance of urban health in Zimbabwe, with urbanisation on the rise the need to understand the population distribution in relation to the health facilities and the epidemiological patterns to inform on policy and practices of governance of urban health. The study examined the interaction of population distribution, the number of health facilities and the epidemiological patterns in the urban areas of Zimbabwe to understand the actions needed to address the health needs of urban dwellers. The study used a qualitative research approach with a case study research design to understand the population distribution in relation to health facilities and epidemiological patterns in urban Zimbabwe. The study showed that a proportion of the Zimbabwean population dwell in urban areas and service delivery in terms of health facilities is poor in some urban centres. The study showed that cholera, HIV & AIDS and mental health challenges are the main urban health challenges in Zimbabwe. The study concludes that underdevelopment in post-colonial Africa remain a scar on humanity aided by corruption. The study recommends new regional and town planning strategies.

Zimbabwe's independence in 1980 witnessed increased government responsibility in the provision of social services for the majority African population, who had been neglected under British colonial rule (Mhike and Makombe 2018). Education and health were key areas of government focus and agents for economic development in line with the new policy changes, the government expanded existing infrastructure and increased capital investment in social services (Mhike and Makombe, 2018). However, government policy realignments and financial investment in key sectors of the economy engendered an overarching narrative that overshadowed the function of non-state actors in the development agenda (Agere, 1997). The capacity and ability of the state and its institutions is key in public service delivery (Brinkerhoff 2011). The Zimbabwean state shows weak capacity, often leading to public service delivery failure (Muchadenyika, 2017). Post-

2000, Zimbabwe went at phenomenal speed from being a regional leader in Southern Africa to becoming an international pariah (Gretchen and Scott, 2011).

The country spiralled downwards heading towards a crush due to poverty with most of the vibrant sectors such as the health care system failing to keep up with the crisis. In particular, Zimbabwe recorded unprecedented regression in key human development indicators as the state failed to provide public goods and services to its citizens (Muchadenyika, 2017). At local government level, public health, local authorities address critical issues of service delivery in the daily lives of population (Kamete, 2003). However, local authorities in Zimbabwe are failing to provide water sanitation, health, education, transport and housing services to citizens (*ibid.*). The magnitude of service delivery collapse is typified by some various diseases that result in out breaks every now and then such as the cholera epidemic that claimed 4,000 lives the highest rate in Africa in over a 15-year period (ICG, 2009; Acemoglu and Robinson, 2013).

The political crises that the country has endured since the year 2000 has seen the country moving backwards in terms of development as there are no infrastructural developments in urban areas as far as health care system facilities are concerned compounded with poverty the existing facilities are failing to curtail the epidemics in urban areas. Undeniably, in urban Zimbabwe, the urban governance crisis has led to service delivery failure (Muchadenyika and Williams, 2016). Planning is at the heart of sustainable urbanisation and is the main conduit of urban governance (UNHABITAT, 2010). Urban challenges such as slums, urban sprawl, urban poverty and poor service provision are explained largely by present urban governance systems and urban planning approaches (UNHABITAT, 2009). Urban and regional planning in Zimbabwe has been poor as there are no health facilities spread across urban areas coupled with poor service delivery Zimbabwean urban areas have seen a surge in the spread of epidemic diseases. Urban service delivery relies on the functioning of urban governance systems therefore; good urban governance is a sign of urban service delivery (Muchadenyika 2014).

Poor urban delivery has seen the health sector in Zimbabwe deteriorate in delivery sound health care system leading to the rampant spread of diseases without control in the country. In an era marked by evolving global health challenges, shifting demographics and epidemiological transitions, the need for effective rehabilitation has become increasingly evident (Charumbira 2024). About one sixth person lives with some disability and 2-4% of them have a severe, permanent disability (World Health Organisation 2011). The exponential increase in chronic health conditions, aging populations, and humanitarian crises resulting from climate changes, armed conflicts and violence in addition the recent COVID-19 pandemic contributes to the growing prevalence of disability and associated functioning problems in people of all ages (Ambrosino *et al*. 2020; Groce 2018). The Global Burden of Disease consortium devised metrics, such as Years lived with disability (YLDs), to estimate and track the burden of disability in countries and globally (Jesus *et al*., 2019).

The way a health system is financed has a significant bearing on the performance of its key functions of stewardship, inputs creation, services provision and ultimately, the achievement of the health system goals (Mutopo 2017). Invariably, the goals of a functional health system include improved health service delivery and responsiveness to people's medical expectations (Kirigia *et al*., 2006). The major objectives of health financing are to make sure that funding for the health system is made available, ensure that all individuals have access to effective public health and personal health care (Fretheim *et al*., 2014). Developing economies are the major recipients of health care finance as they are more often beset with resources constraints faced with multitude of social objectives, governments in developing countries, as the custodians of funds, lack the capacity to drive health programmes (Mutopo, 2017). The World Health Report (2000) has argued that health human resources are key determinants of the success or failure of the health systems as the performance of health care systems is a function of the availability know-how, skills mix and motivation of personnel delivering services. Zimbabwe, like many other countries in the region, is badly affected by a shortage of health care facilities and health workers due to the mass exodus of the health care workers to high-income countries in search of a better living.

The growth of urbanisation in Zimbabwe compounded by poverty and poor economic performance of the country has caused a problem in the country as the number health facilities is less than the population living in the urban areas with some urban centres lacking health service delivery facilities leading to the uncontrolled spread of epidemics. The number of disease outbreaks in Zimbabwe's urban centres that the country's health system fails to contain presents a problem that signal the shortage of health facilities in urban centres of Zimbabwe. The population distribution, health facilities and epidemiological patterns in Zimbabwe presents a developmental problem as it all points towards underdevelopment in the post-colonial Zimbabwe that has a population that continues to rapidly grow outmatching the infrastructural development pace.

The study aims to understand the population distribution, health facilities and epidemiological patterns, towards policy and practical models to inform governance of urban health in Zimbabwe. The study examines the nexus between population distribution and health facilities in urban areas of Zimbabwe versus epidemiological patterns. The study adds to the existing literature pointing towards new direction on the infrastructural development or lack thereof in Zimbabwean urban areas as population growth has become a reality in the urban centres of Zimbabwe. The study is important as it can inform models of policy making in the governance of urban health in Zimbabwe. It is at the backdrop of the need for policy and practical models to inform governance of urban health in Zimbabwe.

The study concept of institutionalised social inequality as the conceptual framework that guided the study. The existence of social inequalities in health is well established with higher education status, and income have lower morbidity and mortality (Beckfield *et al*., 2015). Although social inequalities in health exist in all societies worldwide the degree of these inequalities varies spatially and notable differences exist within Africa (*ibid*.). Social institutions affect health inequalities the relationship between welfare state and the distribution of population health build on and contributes to developing of an institutional stratification (Taylor *et al*., 2004). Health services are not equally distributed in communities and there is an inequality in the responses to diseases in African institutions with less being done in

low-income areas to reduce some of the epidemiological challenges faced in these areas. The concept is relevant to the study as it points out to the formation of health inequalities and the increase in diseases burdens in the low-income urban communities leading to the mass mortality and morbidity in these areas affecting the national development agenda.

This section presents a literature review based on past studies to inform the study on the health in other countries and Zimbabwe. improved health and wellbeing are the goals of healthcare delivery system in the world (Azetsop and Ochieng, 2015). The independent Zimbabwe inherited a racially divided health sector, skewed towards urban, curative health care as such it sought to redress colonial racial inequalities and improve social services provision and infrastructural base of the economy (Mhike and Makombe, 2018). For the black majority of Africans, health and education were key areas which had suffered decades of neglect and underfunding state-funded colonial formal health care was largely a preserve for white community and marginally directed towards African health (Matikiti, 2009). Health resources distribution followed the pattern of white settlement mainly in towns and mining areas as successive colonial governments adopted a curative health policy for Africans which was cheaper to operate as compared to preventive health (Mhike, 2017). The neglect of African care needs was most glaring in infrastructural disparities between white dominated urban centres and the rural areas where most Africans lived (Shoko and Zvobgo, 2016).

The post-colonial state of Zimbabwe encountered several issues in the provision of health care. Mangundu *et al.* (2023) observe how in developing countries like Zimbabwe, access to healthcare services is often influenced by long distances and travel times to health facilities, the availability of financial resources to travel or pay for care and the availability of medical drugs and competent healthcare workers. In Zimbabwe people in rural areas often have to walk between 10 km and 50 km to access the nearest health facility (Loewenson *et al.*, 2014). Access can further be impeded by a lack of infrastructure, such as dirty roads that are not maintained, resulting in poor road conditions and potholes that create barriers to transport (Broni *et al.*, 2014). In Zimbabwe, because of economic challenges, bridges that have collapsed because of rain are not repaired, hindering traveling of patients

during critical times and negatively affecting the timely delivery of medical drugs and medical supplies to rural health centres (Manjengwa *et al*., 2022).

Zimbabwe has been affected by a political crisis that translated into the most severe economic crisis in its history from 1999 to 2008 that led to the signing of the Government of National Unity in 2008 (Mangundu *et al*., 2022). The negative effects on the health care resources in Zimbabwe were evident as the population failed to receive health care services (Mackworth *et al*., 2021). The economic crisis resulted in the deterioration of health infrastructure such as health facilities, resulting in the closing of some public health facilities, either due to lack of medical supplies and health workers or financial resources for maintenance of health facilities (Makoni 2019). Even where medical services are available and affordable, access to medical drugs is limited there is often shortage in the supply of medical drugs especially in rural Zimbabwe (Nyazema, 2010). The economic crises in Zimbabwe has caused community outreach programmes to be closed, as they were likely to place a further burden on few available human resources (Mhere, 2013). The family planning distribution programmes in the rural areas has crumbled, as family planning drugs are not available and thus the birth rate has increased (Zimstat, 2016).

There were challenges with access to antiretroviral drugs for people living with HIV in the rural areas because of shortages, transportation challenges and nurses' attitudes at designated rural health facilities (Tafuma *et al*., 2018). Health facilities that were able to function experienced shortages of medical drugs and material resources such as cotton wool bandages, sutures and medical needles that are crucial in the offering of quality healthcare (Kidia, 2018). Zimbabwe lost, during this time large numbers of healthcare workers, including professional nurses and physicians (Makoni, 2019). The nurse ratio per 1000 of the population decreased from 2.5 in 2017 to 1.95 in 2019 the numbers are expected to decline due to economic hardships, forcing nurses to look of other opportunities (Kidia, 2018). In addition, the healthcare system was overwhelmed by intermittent strikes by health workers due to low remuneration and poor working conditions including a lack of medical equipment (Mackworth-Young *et al*., 2021; Amstrong *et al*., 2020). The economic crises affected the health delivery in Zimbabwe degrading the

profession of healthcare provision leading to the mass exodus of healthcare profession.

The study used a qualitative research approach with a case study research design. Creswell (2011) observes how qualitative research approach is a methodology of exploring and understanding the meanings of social facts ascribed to social problems as avails an opportunity to understand phenomenon in the natural setting. The allure of qualitative research approach is that it is good at simplifying and managing data without destroying complexity and context (Yin, 2011). The study used secondary information on the data collection. As Yin (2016) observes the literature review-based approach of data collection can help the researcher build new insights and fill in the blank gaps in the past studies while keeping up with the current trends in the field of study. The study used thematic data analysis to analyse the data and the information that emerged from the study. Thematic data analysis is the process of identifying patterns or themes within qualitative data Braun and Clarke (2006) observes how it is the first qualitative method that should be learnt as it provides core skills that were useful for conducting any other kind of analysis. The allure of thematic data analysis was that it identifies themes that is patterns in the data that are important and use them to address the research questions.

The study aimed to population distribution, health facilities and epidemiological patterns: towards policy and practical models to inform governance of urban health in Zimbabwe. Worldometer (2024) observes how the population in Zimbabwe is 17,043,659 million people 36.7% of the population is urban (6.117,511 people). The Government of Zimbabwe (2018) observes how health care in Zimbabwe is provided by public facilities, nonprofit groups, church organisations, company-oriented clinics. Masuka *et al.* (2017) observe how the population of Zimbabwe 16 million (67% rural and 33% urban) with 6 central hospitals, 8 provincial hospitals, 15 Polyclinics, 96 City council clinics, 69 Private clinics. Mugwagwa *et al.* (2017) observes how Private Hospitals Association of Zimbabwe (PHAZ) was formed in 1996, and the founding members were The Avenues Clinic Harare, St Annes Hospital Harare, Borrowdale Hospital Marondera, Seventh Avenue Surgical Unit Mutare, Claybank Clinic Gweru and Colin Saunders Triangle. Mhandu *et al.*

(2016) observes how urban areas in Mashonaland West province have poor health services provision.

Chazireni (2018) observes how a large proportion of the administrative districts in Zimbabwe and urban Mashonaland West province have poor health conditions in both people's state of health and health service provision. Relief Web (2023) observes how in Zimbabwe most provinces have provincial hospitals except for Harare and Bulawayo that have central hospitals that work as referrals to treat people from other provinces. The Herald (9 April 2024) observes how the Government of Zimbabwe opened health centres in Stoneridge Harare and Cowdray Park in Bulawayo offering outpatient maternity, ART and inpatient facilities.

Tapfumanei *et al*. (2023) observe how in there has been epidemiology and microbiological pattern of cholera outbreak in the urban centres of Zimbabwe with Harare and Chitungwiza being the most affected areas due to poor service delivery in these urban settlements that lack water supply. Fernandez *et al*. (2012) observe how in a highly populated African urban area where clean water is a challenge like Harare with rampant sewage disposal running off the slopes cholera became the resultant disease in 2008-2009 compounded by the economic and political situation the epidemic disease claimed lives across Harare. Olatunji *et al*. (2024) observe how in Zimbabwean urban areas such as Harare and Chitungwiza due to clean water shortages cholera outbreaks have been reminders of the state of poor service delivery in the country's urban centres. Voice of America (24 January 2024) observes how in urban areas in Zimbabwe extreme climate conditions are causing cholera outbreaks.

UNAIDS (2020) observes how in major urban areas, of Harare, Bulawayo, and Chitungwiza HIV prevalence among antenatal clinic attendees tested increased Zimbabweland (27 September 2020) observes how in border towns like Chiredzi there is a mass spread of HIV and AIDS as unemployment is leading to transactional sexual relation with even the youths indulging in these risky behaviours. WHO (2017) observes how HIV prevalence in Zimbabwe has consistently been higher in urban areas as the country remains one of the 30 countries with the highest burden of TB, TB-HIV and drug-

resistant TB. Mugurungi (2007) observes how urban spaces in Zimbabwe have been affected by the HIV epidemic with impacts such as sustained crisis-level adult mortality among the economically abled age groups.

Nyabani (2021) observes how exacerbated by economic hardships Zimbabwean urban areas are leading in drug abuse strongly related mental disorders and communicable diseases resulting in the country having a double urban epidemiological burden. Marandure *et al*. (2023) observe how in the urban areas of Zimbabwe the disease burden has been increased by drug and substance abuse as it is resulting mental health challenges among the youths. Nhunzvi (2019) observes how in Zimbabwe the socio-economic hardships have pushed most youths to abuse drugs substances resulting in the epidemiological burden in the country as a result of mental health issues among the youths. Matunhu and Matunhu (2015) observe how the drug abuse problem in urban centres of Zimbabwe such as Harare has grown into a disease problem with most of the youths that use substances and drugs suffering mental health challenges.

The study aimed to population distribution, health facilities and epidemiological patterns: towards policy and practical models to inform governance of urban health in Zimbabwe. the study showed that a small proportion of the population in Zimbabwe reside in the urban areas with the greater part of the population residing in the rural areas. The study showed that only two cities in Zimbabwe have central hospitals that work as referrals for the people from provincial hospital. There is a lack of infrastructural development in the urban areas in Zimbabwe as there are Polyclinics not hospitals in these areas in Zimbabwe. The study shows that there is a lack of infrastructural development in the developing world. Concurrent with the study is Edoh (2021) that observes in low-and middle-income countries, the developing world there is poor development of health delivery services facilities with most of the urban areas lacking access to health services within an understandable distance. The lack of infrastructural development, the population growth, and the growth of urbanisation is exposing the urban dwellers to mortality as there are no health delivery services nearby. The implication of these findings on policy and practical models to inform governance of urban health in Zimbabwe is that they point towards the

decentralisation of the health sector through mass infrastructural development.

The study showed that there has been epidemiology and microbiology pattern of cholera outbreaks in the post-colonial Zimbabwe in the urban centres due to poor services delivery and underfunding of the health sector in the country. The study revealed that the urban areas in Zimbabwe have a pattern of being attacked by cholera in rain seasons as the sewage run off uncontrolled during these times causing deaths from cholera. There has been a lack of development in the sewer systems and the drainage system in the urban areas of Zimbabwe as most of the service deliveries that are in place were not prepared for the growth of urbanisation to the current state. Compounded by the poor health service delivery in Zimbabwe and the economic hardships that the country has endured the underdevelopment in the country has been exposed as cholera has seized to be a major health threat in the developed world. The study showed that inadequate access to clean water was the major cause for cholera outbreaks in Zimbabwe. in support of the study are Zerbo *et al.* (2020) that observes how cholera remain a major scourge in sub-Saharan African populatio0n as it is contracted by consumption of contaminated water and food in urban centres. The implication of these findings on urban policy and practical models of urban health governance is that of smart-water management that emphasis on the development of water re-use for non-domestic use and drilling of boreholes for safe drinking water.

The study revealed that Zimbabwe urban areas just like in any other developing countries have an epidemiological pattern of HIV prevalence. Compounded by the economic hardships transactional sexual relations in the urban centres were causing the disease burden for the underfunded urban health facilities. Concurrent with the study are Magadi *et al.* (2017) that observes how in Kenya HIV is high among urban dwellers with most of the youths in colleges being affected. The study showed that in the urban centres of Zimbabwe drug and substance abuse have presented another epidemic pattern of mental health challenges that are affecting most of the youths that are trying to escae the impacts of unemployment and other psycho-social challenges. The country has seen the development of a double burden through drug and substance abuse as it has resulted in investments in the drug abuse

eradication and mental health services. Concurrent with the study are Onaolao *et al*. (2022) that observes a a rapid increase in substance abuse causing mental health challenges that are burdening the poor health care delivery systems in developing countries. The implication of these findings on urban policy and practical models of urban health governance is that they point to the need for investments in the education of people on the health burdens that are associated with drug abuse and the provision of rehabilitation services in urban centres.

The study aimed to population distribution, health facilities and epidemiological patterns: towards policy and practical models to inform governance of urban health in Zimbabwe. The study revealed that in Zimbabwe with the growth of urbanisation a considerable proportion of people reside in the urban areas. The study showed that there are various disease patterns in the urban areas of Zimbabwe with some of them pointing towards a lack of development and poor service delivery in the country. The study concludes that the Zimbabwean health sector has been in the intensive care since the year 2000, as there has been a lack of funding and poor policy towards infrastructural development. The study concludes that the poor performance of the health sector in Zimbabwe is compounded by the poor service delivery in the urban centres that is establishing epidemiological patterns through diseases that points to lack of waste management and drainage system development. The study concludes that the epidemiological patterns established in the urban centres of Zimbabwe points to a developing problem of poor policy framework as the country continues to shine on state-controlled media whereas the reality on the ground speaks volumes of underdevelopment. The study concludes that the state of health facilities in the urban centres of Zimbabwe presents a genocide as the lack of development and improvement of service delivery betrays a sabotage of the urban poor by the state. The study recommends the crafting of smart-water management policies in the urban areas. The study recommends the greening of urban centres to reduce the impacts of climate change on urban areas and reduce the disease burden. The study recommends the implementation of policies that remodify the drainage systems in urban centres to match the population growth. The study recommends a zero tolerance to corruption policy to reduce the urban drug and substance abuse conundrum.

To provide policy and workable models for managing urban health in Zimbabwe, the present chapter has examined epidemiological trends, health facilities, and population distribution. In order to influence governance policies, the study has attempted to explore the relationship between population distribution, health facilities, and epidemiological patterns as urbanisation increases. A case study design combined with a qualitative research methodology has been used. A sizable section of Zimbabweans live in cities, but some places continue to have subpar health care delivery. According to the survey, the main urban health issues include cholera, HIV & AIDS, and mental health issues. advancement, made worse by corruption. In order to enhance urban health governance and service delivery, the report suggested implementing new regional and municipal planning techniques.