

DOI: <https://doi.org/10.24297/jssr.v14i0.8050>

Health Service Delivery Complexities in Mutare Urban, Manicaland Zimbabwe

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Abstract

This research study sought to identify the health service delivery challenges in urban areas using Mutare as a point of reference. Interviews, focus group discussions and observations were used to collect data from selected residents of Mutare city. Mutare city is experiencing poor service provisions and serious health service delivery challenges. This is witnessed by high doctor to patient ratio, high infant and maternal mortality rates as well as high incidences of malaria and other infectious diseases. The challenges are not limited to drugs and medical facilities, medical staff, transport, distance and referral mechanism, costs and financing of services culture and attitudes, corruption and bribery. Recommendations were made regarding the possible adjustment to existing health strategies and policies used in Zimbabwe, for the improvement of the health service delivery system of the city of Mutare. New strategies were also recommended for the improvement of the health system of the city. Lastly, some proposals were made for further research on the health service delivery challenges in rural areas so that comparisons are made to see whether the challenges are the same.

Keywords: Health; Service; Service delivery; Health Service Delivery; Health care; Disease.

1.0 Introduction

According to the OECD (2010), all over the world cities face the most acute challenges of health service delivery because of fast increasing populations. In many countries, especially developing countries, the issue of health service delivery is a challenge that needs to be addressed given the low quality of service provision and the pressing needs of the poor (Besley and Ghatak, 2007). Khalid (2010) supports this view when he indicates that local councils in Malaysia continue facing pressure to get better their service delivery. Tamrakar (2010) affirms that in Nepal, public health service delivery has remained lower than what was targeted when Nepal announced delivery of public services to its people through a planned development effort. The fact that people still go through from many hurdles when they have to get any government services, according to Tamrakar (2010), is a sign of poor service delivery that needs to be addressed. Thus, the problem of health service delivery is not only one of its kinds to Zimbabwean towns alone; it is a problem that is faced by many urban areas in the world, especially in Africa and other developing countries. Booth *et al* (2014) alluded to the fact that, delivery of services has a direct and instant effect on the quality of the lives of the populace in a given community. Hence, as Besley and Ghatak (2007) indicate, improving public health service delivery is one of the major challenges globally.

While Zimbabwe used to have an immaculate and fairly robust health delivery system cherished by many in the sub region, the performance of health service delivery institutions has continued to deteriorate over the years as witnessed by signals of administrative ineptitude on the part of city health authorities. Evidence of poor health service delivery, much to the discontent of the ratepayers, is abounding. This virtual and constant decline in quality health service delivery has long been a cause for concern to both the general public and the rate paying community let alone policymakers and local government operatives. Regardless of the fact that a great deal of their financial resources come from residents, the quality of health services that are being offered has continued to deteriorate. Delivery of health service has remained a great challenge and this has in turn angered

the expectant and cash-strapped citizenry. City health authorities should in conjunction with the national and provincial governments address this problem and it is a crucial responsibility of the government and government institutions to deliver better public health services to the society. This will enable the society's welfare to improve in line with the Millennium Development Goals (MDGs) number four (to reduce child mortality), number five (to promote maternal health), and number six (to combat HIV/AIDS, malaria and other diseases), (Zhou and Chilunjika, 2013). To date, there are limited studies that have formally investigated the health service delivery challenges in urban areas of Zimbabwe. Therefore, this study sought to empirically identify the health service delivery challenges in urban areas using Mutare city as point of reference.

2.0 Materials and Methods

The researcher used the case study research design so as to get the in-depth analysis of the case. A case study research design is therefore concerned with specific predictions, narration of facts and characteristics concerning individuals, groups or situations, (Creswell 2013). It can also be described as an intensive and detailed analysis of a single case. The design utilises qualitative research method. This is because a case study research design is intensive and detailed, therefore requires the semblance of qualitative research methods to obtain reliable data. A case study research design was used since it allowed for the development of the comprehensive and intensive knowledge about a case with a view to establish generalizations about a small section of a wider population. This is the particular population which the study is interested in, and from which the sample is drawn, (Oyedele 2011). Relating to this the researcher's target population included city health authorities, city councillors, medical staff and residents of Mutare city who were able to contribute meaningfully towards the research topic. In actual fact, all the aforementioned people were part of the population from which samples were taken presenting the health service delivery challenges in Mutare city. This research, during the process used two sampling techniques, that is the stratified sampling technique (probability) and purposive/judgemental the technique (non-probability). According to Dillman (2000) quoted in Chabaya (2015), a sampling technique refers to the technique(s) used in depicting samples commencing targeted population, usually in a way that will assist in answering pre-determined research objectives and questions that require answers from the population going to be selected.

Table 1 below shows the population sample for the study which was selected using both stratified and purposive sampling techniques.

Table 1 Population Sample for the Study

Target group/ sample composition	Population of selected areas	Sample population size
City health authorities	12	6
Ward Councillors	19	10
Medical Staff (sister in charge)- from the 12 health centres	12	8
Mutare city residents (wards 1, 6, 11 and 16)	45 892	76
Total	45 935	100

Source: Manicaland Census Report (2012:152) in conjunction with City Council Records (2018).

As it stands, the above table reflects a study population sample from which the researcher chose her sample. The researcher in this case was focused on the city health authorities, councillors, sisters-in-charge of the health centres, and the residents of Mutare city. As evidenced above the sample selection saved time and effort of the

researcher as she conducted the research using few informants with required information. In actual fact the ideal scenario under the population sample was not to test all individuals but to obtain valid, perfect and reliable results. A research instrument is a device or procedure used for the systematic collection of data from the study sample, (Oyedelle 2011). It is a testing device used to measure a given phenomenon. Collecting data is a process of preparing and gathering information from different sources which might be primary or secondary sources, (ibid). Kumar (2011:138) noted that primary sources exist when data is collected using the first approach and that data is gathered purposively as well as specifically for the study at hand whereas secondary data obtained for the use of the study but not originally intended for the research at hand. In this study therefore, the researcher used interviews, observations, and focus group discussions to collect information from the respondents.

3.0 RESULTS AND DISCUSSION

Sex of Respondents

Respondents in this study comprised of both males and females as shown in Table 4.1 below.

Table 2: Sex of respondents N=100

Target population	No. Of males	No. Of females	Total
City health authorities	4	2	6
Ward councillors	8	2	10
Nurses-in-charge	0	8	8
Residents	33	43	76
Total	45	55	100

Source: Field data (2018)

From the table it can be concluded that the respondents were all represented since males constituted 45% of the total population while females had 55%. However, the target population itself was dominated by females than males especially the residents where females were 43 compared to 33 males. The nurses-in-charge were all females while the ward councillors and the city health authorities were male dominated.

Age of Respondents

The respondents' ages are summarised in the table 4.2 below.

Table 3: Respondents' ages N: 100

Age range	Males	Females	Total
0-15	3	4	7
16-25	8	11	19
26-35	10	12	22
36-45	12	15	27
46-55	8	8	16
56-65	4	4	8
>65	-	1	1

Total	45	55	100
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Source: Field data (2018)

From the table above, it can be noted that all age groups were represented by the population sample. This means that the results obtained were a representation of the whole population in Mutare city. The range from 0 to 15 had constituted 7% of the total population. However, the dominant population were those aged between 16 and 45 years who constituted 68% of the total population followed by those between 46 and 55 years. About 9% of the respondents fall under the age range from 55 years and above and these are city health authority top officials.

Marital status of respondents N: 100

The marital statuses of respondents are summarised in figure 1 below.

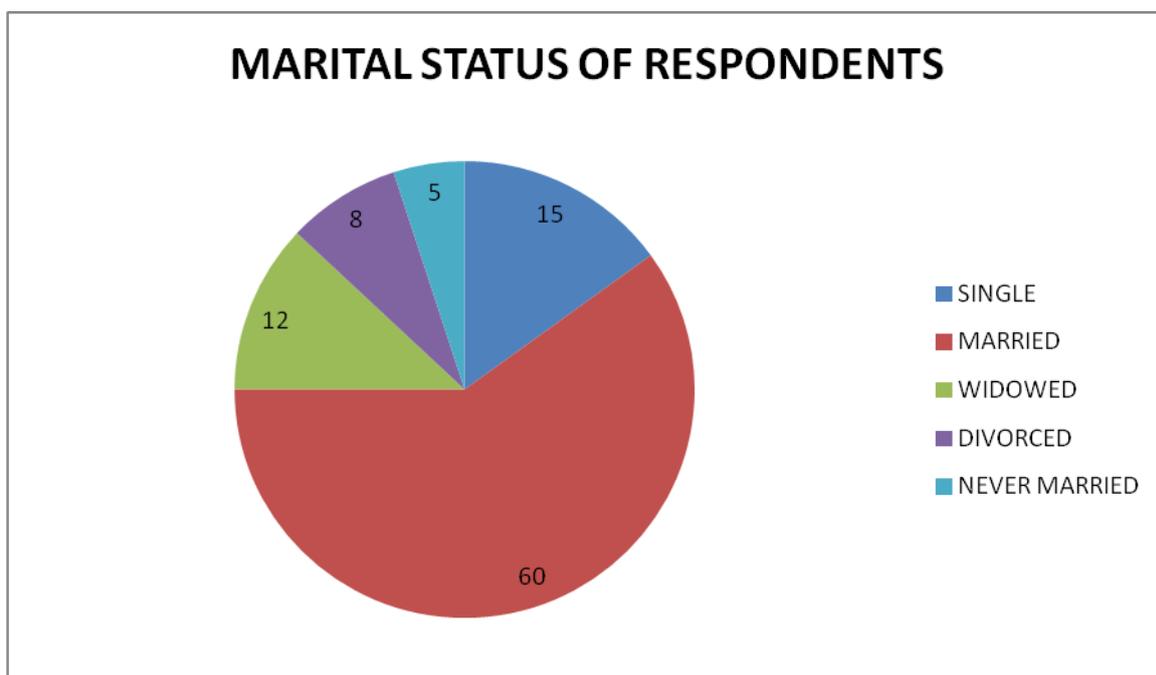


Figure 1: Marital status of respondents

Source: Field data (2018)

The majority of the respondents were married and constituted 60% of the total population, followed by those who were single (15%). The smallest group constituted those who never married. This means that the target population represented all the social characteristics of the residents of Mutare city.

3.1 Health Service Conditions in Mutare City

On the health service conditions in Mutare city one interviewed married male respondent of age range 26-35 had this to say:

In this city there are very few specialist doctors and all those who need specialist services have to be referred to Parirenyatwa in Harare. Another problem is the failure to acquire drugs. People pay a \$7 fee for cards at clinics but there are no drugs. The clinics just write a prescription and you are supposed to purchase the drugs from a pharmacy. Most people die because they do not have money.

This actually shows that the residents had problems in the payment of the medical fees even though they knew the dangers of lack of medical personnel and drugs. This is also in support of Mosadeghrad (2014), who argued that public hospitals in urban areas lack drugs while some may only have panados in stock.

Another local married female resident of age range 35-45 who was one of the focus group discussions said this when asked about health service conditions in the city: *"Although the local government constructed some clinics in the city, most of the structures are now white elephants due to lack of manpower and drugs."* This actually shows that residents are being sent home without proper treatment at the clinics due to lack of medical supplies. This concurs with Dogba and Fournier (2009), who indicated that the subsequent devaluation of the national currency under SAP had devastating consequences on health service delivery since it made imports more expensive and thus creating serious supply shortages in pharmaceutical goods and other medical equipments.

In addition, as observed by the researcher, there were a number of health problems in the environment. While safe water and sanitation facilities are present in the city there is unreliable functioning, prolonged cuts leading to use of unsafe alternatives which undermine health, as well as waste disposed in open pits and public sites as shown in plate 4.1 below.



Plate 1. Source: Field study 2018

This actually shows that residents have created their own dumpsites by the roadsides which become breeding grounds for parasites. This also concurs with Chingenya (2010) who argued that waste disposal is also found in open pits and public sites in most urban areas of sub-Saharan Africa posing a health hazard to residents.

On health service conditions in the city the researcher also observed that the public toilets at bus terminals, which are usually next to fruit and vegetable markets and in the residential areas of Sakubva are rarely cleaned; and that street kids and the general citizenry simply dispose of litter anywhere and anyhow instead of disposing of it as it should be in the trash can or dustbin. This is in support of Booth et al (2014) who argued that the result would be reported higher urban diarrhoeal disease rates than in rural areas.

Furthermore, the above observation was supported by a single male respondent of age range 16-25 among the focus group discussions who mourned that: *"the state of communal toilets in suburbs like Sakubva and*

Dangamvura is deplorable and they are not even in function which poses a health hazard to the residents.” This is an unfortunate scenario as public toilets can by no means be avoided as nature calls are eminent thus putting everybody to a health risk as the toilets become infested with not only maggots but also intoxicating smell.

Another female married in the age range 26-35 interviewed on health service conditions had this to say: *“we are facing challenges in meeting nutritional needs for ourselves and the children because of the current economic situation.”* This actually shows that some residents are going without proper nutrition and is in line with Nembhard et al (2009) who reasoned that health service provision in many urban areas has been undermined by HIV/AIDS, poverty, economic decline, social inequalities as well as political discord and as a result, communities have experienced outbreaks of epidemics and declining service quality.

Furthermore, another male respondent of age range 65+ among the focus group discussions when asked about the health service conditions in the city had this to say: *“We have to commute to our nearest clinics which are more than 5km from our usual places of residence”.* This actually shows that clinics in the city are unevenly distributed and are few as compared to the entire populace. This concurs with Nembhard et al (2009) who argued that health care centres in many countries are far apart such that many people face difficulties in accessing them.

In addition, one married female respondent of age range 26-35 interviewed on health service conditions also had this to say:

The increase in the number of commuter omnibuses and taxies has also resulted in the increase of rank marshals and ‘hwindis’ (touts) in this city. These people pollute the streets and service lanes, that are used as entry points for deliveries for several shops and businesses to particular buildings, with faeces, used condoms and a whole range of plastics and thus posing a serious health hazard.

This is a pure sign that the touts have no bound laws that they respect, thus their disrespect of humanly health living put all the other residents in speculative health problems. This is in support of Booth et al (2014) who indicated that street kids and the general citizenry simply discard litter anywhere and anyhow instead of disposing of it properly in the trash can or dustbin.

3.2 Efficiency of Clinics in their Service Delivery

When asked about the efficiency of the local clinics and hospitals in their service delivery, one married female nurse-in-charge of age range 45-55 had this to say:

Access to health here is really difficult. People are dying from curable diseases. Our clinics do not even have stop pains like paracetamols. All we are giving now are prescriptions but the general populace does not have money to buy the drugs at pharmacies. The rights to health in the constitution are only there on paper not for the entire population.

This shows that there is scarcity of drugs in public hospitals and clinics in Mutare. This is in line with Gakii (2013) who argued that many patients are going without proper treatment due to absence of drug stocks in public health centres. This also in support of Mosadeghrad (2014) who argued that drug and drug stock outs and shortages are also a characteristic of urban health systems in developing countries and this force people to prefer seeking care from higher level services at considerably greater distances, with higher costs to households and services.

In addition, another single female respondent of age range 16-25 among the focus group discussions had this to say when asked about efficiency of clinics:

All public clinics do not have doctors; they only have a few nurses most of whom are students on attachment, hence some of the illnesses and diseases are beyond their capacity to treat. The end result is that many patients

are being sent back home without being treated while others are recommended for home based care. At the district and general hospitals where doctors are available, the doctor to patient ratio is frightening and in most cases the doctors cannot treat all the patients but attend only to the critically sick.

This actually shows a shortage of health personnel in both public clinics and hospitals and thus those available cannot meet the high demand of patients seeking healthcare they meet on a daily basis. This concurs with Mills et al (2012) who contended that in many countries in Africa, an overwhelming mainstream of health workers are concentrated in a few urban areas meaning that all categories, particularly nurses and doctors, are in short supply compared to the standards of population ratios for nurses and other health workers.

3.3 Health Service Delivery Challenges in Mutare City

On health service delivery challenges one of the married male councilors of age range 35-45 interviewed noted:

Council and government clinics simply give patients prescriptions and then ask them to go and purchase the medicine and drugs at private pharmacies due to shortages of drugs. The fact that most of these private pharmacies charge exorbitant prices which most of the urban poor cannot afford means that many die prematurely.

This actually shows that there are drug supply stock outs and shortages in the public clinics and that many patients cannot afford to purchase drugs from pharmacies.

Another single male respondent among the focus group discussions had this to say on health service delivery challenges:

The country at large has been losing healthcare professionals to neighboring countries due to the economic challenges that confronted the country. This means that most of the experienced doctors have left the country leaving the young and inexperienced ones and thus putting public health at risk.

This also show that most public clinics are understaffed and thus cannot cope with the number of patients coming for medication and treatment and that those health personnel available are unable to deal with major illnesses. This concurs with Bakeera et al (2009), who observed that the lower health care units in Uganda were mainly staffed by unskilled ward maids or dressers that formed 40% of the work force who are more often than not school dropouts that got trained on the job and are reported to run most of the lower unit levels because trained nurses were not available and that these people lack knowledge which is essential for designing a need-based pro-poor health system.

One widowed female of age range 46-55 interviewed also had this to say on health service delivery challenges:

The country is still using the 1983 staff establishment when the population was about seven million. However, the population has since doubled and likewise the disease burden has also increased considerably. The problem is also exacerbated by meager salaries received by health professionals which results in them engaging industrial strikes at the expense of patients. This has been witnessed recently as junior and middle-ranking doctors laid down their stethoscopes in protest against poor remunerations and pathetic working conditions characterised by absence of basic drugs and other tools of trade.

This actually show that no health personnel have been recruited recently and that those employed are earning low wages which end up forcing them to engage in industrial strike which has far reaching and devastating consequences as several people who could have survived will end up losing their lives. This is in support of Mills et al (2012) who argued that payments for staffs in government health facilities especially doctors, medical assistants and those with nursing training is not commensurate with services rendered hence they tend to develop their own survival strategies, often not in line with official government strategies.

Furthermore, one married male respondent of age range 46-55 among the focus group discussions when asked about the health service delivery challenges had this to say: *"Can you imagine, this whole city is being serviced by only two ambulances which in most cases either do not have fuel for emergency errands or have missing wheels."* This clearly shows poor emergency responses within the city which result in patients dying of treatable diseases. This is in line with Dogba and Fournier (2009) who indicated that many cities lack emergency responses as health facilities might be damaged, destroyed or besieged and the health workforce might be lost, leaving people with restricted access to health and emergency services when they are most needed.

In addition, the researcher observed that water distribution equipment and the sewerage system in Mutare city has hardly ever been renovated or replaced since it was laid down and due to this limited maintenance of the sewerage system, sewerage pipes have been continuously bursting, thereby contaminating some of the water sources that are being utilized by the residents confronted with water blues, thus exposing them to a number of related diseases. This was also supported by one never married female respondent of age range 36-45 in one of the focus group discussions who had this to say on causes of the health service delivery challenges:

Most of the problems associated with bursting of sewer pipes emanate from the fact that existing amenities in this city were planned and laid down to accommodate smaller population demands, but however, the rapidly growing urban population has increased pressure on available amenities and resources.

This clearly shows that while the urban population in Mutare city perpetually increases, there has not been any corresponding increase in the quantity and quality of public infrastructure and services.

Furthermore, one single female respondent of age range 26-35 in one of the focus group discussions had this to say on health service delivery challenges: *"There are rampant corrupt activities within the town and the nation at large which have a debilitating effect on the city health authorities' capacity to effectively carry out duties of health service delivery."* This is in line with Munzwa & Jonga (2010) who noted that corruption, the lack of transparency, and general mismanagement in institutions like the town council has influenced experts to call for the implementation of good governance in such public institutions as this consequently lead to a decline in the quality and quantity of health services provided within the city.

One married male of age range 46-55 interviewed also had this to say on the challenges:

Treating Sexually Transmitted Infections is resource intensive, and unless done in conjunction with a concerted campaign to change sexual practices, is unlikely to have a significant impact on AIDS and the fact that the government's response has not been commensurate with the scale of the epidemic, it may claim more than a million lives in the next decade.

This depicts that HIV/ AIDS epidemic is one of the most serious problems facing the health system in the city since it is draining more resources at the expense of other health matters. This also in support of Dogba and Fournier (2009), who argued that the epidemic even affects the health workforce and in so doing reduce the quality of their work.

Furthermore, one married male respondent of age range 26-35 among the focus group discussions had this to say:

We do not have access to coverage of malaria spraying which is inconsistent if there and yet the city was declared a malaria zone. Even schools and health centres lack nutrition gardens to provide therapeutic or community intervention for nutritional needs.

This clearly shows that there are gaps in the resources and support for prevention and promotion actions by Environmental Health Technicians as well as clinics that leave communities vulnerable and dependent on curative care. The Environmental Health Technicians are not given the necessary support and resources they need to carry out their duties. This concurs with the studies carried by the UN, Habitat (2009) and is also in

support of the observations carried out by the researcher where inconsistent garbage collection has resulted in residents creating their own dumpsites by the roadsides (Plate 4.1) posing a health hazard to them.

In addition, one married female of age range 26-35 interviewed on challenges mourned that:

Nearly one in every five maternal deliveries were done outside the area of residence, as only two local clinics that is Dangamvura and Sakubva clinics offer such services. There are also no waiting mother shelters in both public and private health centres in Mutare city hence discouraging uptake of assisted deliveries.

This clearly show that maternal assisted deliveries uptake is not well catered for in the city as there are no waiting mother shelters in the health centres and the fact that maternal delivery clinics are too far for many residents poses a serious health risk to expectant mothers.

In addition, solid waste that is not properly collected and disposed of as was observed by the researcher (Plate 4.1) and this has turn out to be a breeding ground for insects, vermin and scavenging animals leading to the passing of air and water-borne diseases. This concurs with the surveys conducted by UN-Habitat (2009), which demonstrate that in areas where waste is not collected regularly, the incidence of diarrhoea is twice as high and acute respiratory infections six times higher than in areas where collection is frequent.

Furthermore, the researcher also observed air pollution from the burning of dumps and skip bins in and around residential areas of which long term exposure to this can affect the central nervous system, causing headaches, weakness, fatigue, and depression. Some refuse was also observed by the researcher which had been thrown into the drainage system. This was in support of Booth et al (2014) who argued that such refuse blocks the flow of water which in the long run causes flooding and consequent water borne diseases like malaria and typhoid.

3.4 Causes of the Health Service Delivery Challenges

When asked about the causes of the health service delivery challenges in Mutare a married female of age range 26-35 interviewed had this to say:

Our government is failing to meet the Abuja Declaration threshold which calls for 15% of the national budget to be allocated towards the health sector. About \$250 million has been allocated to the health sector for the 2018 fiscal year and this represents about 9.8% of the total budget which is far below the Abuja target.

This actually shows that there is poor funding of the health sector hence poor service quality. This concurs with Awiti (2014) who argued that poor funding of the health sector in developing countries has put it in shambles which was coupled by the Structural Adjustment Programmes adopted by many countries which forced many preventive programs to suffer from financial along with technical constraints, community health systems being dismantled or whittled down, and public health outreach programs disappearing. This was supported by a single male respondent of age range 25-35 in one of the focus group discussions who had this to say:

What we are getting from the donors has helped in averting a big disaster in public health, but it is important to note that it still remains inadequate forcing hospitals to deny the poor who cannot afford tertiary care services to access health care. As a result, public health centers in the city are operating well below their capacity because government cannot afford to buy drugs and fund other essential operations.

This actually show that there is also an over dependence on donor funding in Mutare and that the city itself is failing to increase domestic financing towards health programmes. This concurs with Gakii (2013) who indicated that funding from the donor community under the Health Transition Fund (HTF) aims at improving maternal and child health and nutrition, as well as ensuring the provision of essential medicines, vaccines plus basic medical equipment; meaning that without the donor community, Africa's public health system would have virtually collapsed given that it is funding the mainstream of the health programmes. However, if the political relations turn sour the donors would run away.

In addition, the researcher observed that water distribution equipment and the sewerage system in Mutare city has seldom been renovated or replaced since it was laid down and due to this limited maintenance of the sewerage system, sewerage pipes have been constantly bursting, thereby contaminating some of the water sources that are being utilized by the residents confronted with water blues, thus exposing them to a number of related diseases. This was also supported by one never married female respondent of age range 36-45 in one of the focus group discussions who had this to say on causes of the health service delivery challenges:

Most of the problems associated with bursting of sewer pipes emanate from the fact that existing facilities in this city were designed and laid down to cater for smaller population demands, but however the fast increasing urban population has increased pressure on available amenities and resources.

This clearly shows that while the urban population in Mutare city perpetually increases, there has not been any commensurate increase in the quantity and quality of public infrastructure and services. This concurs with Chigwenya (2010) who reasoned that increasing influx of people from rural areas due to urbanization has had a negative impact on the way services are delivered in the city.

In addition, one married female respondent of age range 46-55 interviewed had this to say on causes of the health service delivery challenges: *The economic structural adjustment programmes introduced in the 1990s led to the introduction of user fees in all clinics and hospitals forcing many people especially the poor to delay seeking healthcare.* This concurs with Bakeera et al (2009) who argued that such cuts in expenditure due to SAP strike health services hardest since most patients were too poor to pay user fees and had a devastating blow in rural areas and urban slums.

3.5 State of the Road Network in Mutare City

From the observations conducted by the researcher, it was noted that roads both in residential areas and the major ones are in a dilapidated state which has been worsened by heavy rains which slow down movement of vehicles and even cause road accidents. Plate 4.2 below shows the condition of many of the roads in Mutare city which if no action is quickly taken will soon be closed for public use.



Plate 2 Source: Field study 2018

Some of these roads were refurbished recently but have since been destroyed by heavy rains since no tar was used hence emergency cases (ambulance services) are delayed by these bad roads.

This was supported by a married male respondent of age range 36-45 interviewed on the state of the road network had this to say:

Very little attention has been given pertaining to maintenance, rehabilitation and reconstruction of the existing road networks in the city and most streets that were initially tarred are now looking as if they were never tarred.

This concurs with Jonga (2013) who was contended that while the government and by extension, town council's places roads amongst their highest priorities for investment, exceedingly little attention is being given pertaining to maintenance, rehabilitation and reconstruction of the existing road networks in the towns. This actually shows that most roads in Mutare city are flooded with large potholes and this is posing a threat to traffic as movement is slowed down.

3.6 Residents' Perceptions and Opinions on the State of Mutare City's Health Service Delivery

On residents' perceptions and opinions on the state of Mutare city's health service delivery, one single male respondent of age range 16-25 from the Focus group discussions had this to say:

Mutare city health authorities have failed to address the continuing decline in service delivery. Even the rates they are charging are not commensurating with the services being rendered to residents due to misplaced priorities and lack of strategic direction.

This actually depicts that residents are worried and disappointed about the state of Mutare city's health service delivery for they think the city health authorities have failed to address their concerns.

Another married female respondent of age range 46-55 also complained that:

It is disappointing that the Millennium Development Goals and health for all by 2000 mantra have remained government slogans on public platforms but never transformed our lives in the country. Instead the country is experiencing a worsening health crisis characterised by outbreaks of typhoid, cholera, malaria, HIV and even non-communicable diseases and injuries.

This means that all the hope has been lost among many and that they fear the worst is going to happen in terms of health service delivery in the city.

One married male respondent of age range 56-65 interviewed also commented that: *"corruption, nepotism and lack of political will are slowly ruining the city although the city health authorities point at cash flows as the root cause of the problem."* This clearly shows that Mutare city residents blame the city health authorities for poor health service delivery in the city accusing them of corruption.

Furthermore, another widowed female respondent of age range 35-45 interviewed reiterated that: *"liquidity crisis has resulted in city health authorities failing to treat water, to maintain roads, to purchase drugs, to pay staff and even to collect household refuse."* This clearly shows that liquidity crisis has affected various sectors of economic and social development within the city including the health sector.

Another single female respondent of age range 0-15 among the focus group discussions commented:

There are higher poverty levels among residents; poor health infrastructure; and inadequate and or uneven distribution of healthcare personnel which hinders delivery of quality services. It is sad to note that in the four public clinics in the city a maximum of two qualified nurses are always present and the rest are student nurses on attachment.

This also depicts shortages of health personnel as well as shortage of health centres in the city. This is in support of Awiti (2014) who argued that given the scarcity of qualified health workforce in urban areas and the

unfairness of their distribution, people prefer to seek health care from non-qualified providers in the informal sector, especially the poor and the disadvantaged.

In addition, one married male respondent of age range 65+ on Focus group discussions commented: *"The population influx places a lot of pressure on available sanitation facilities"*. This means that urban sanitation poses a great concern as Mutare city continues to move towards urbanisation

Furthermore, another married female respondent of age range 46-55 interviewed also mourned that:

Our lives are in danger due to improper disposal of household waste as illegal dumpsites are found everywhere within residential areas which have become breeding sites for parasites like mosquitoes although the blame does not entirely fall on the city health authorities but to us residents as well since some of us deliberately ignore the health and safety rules both at workplaces, at public places and even in residential areas. Some of us have even accrued huge debts with the city council thereby crippling their resource base.

This clearly shows that the residents are also to blame of poor health service delivery in Mutare city since some of them are not playing their part to ensure quality health service delivery in the city.

In addition, when asked about their perceptions another widowed female respondent of age range 36-45 interviewed noted that:

Most employers are failing to remit money to medical aid [health insurance] societies as their companies are battling to continue to exist, and coupled with the high unemployment rate means a good fraction of the population suffer since they do not have cash to cover medical bills. As a result, the city's premature deaths are on the rise (both maternal, neonatal, and under-five mortality).

This clearly shows that the majority of residents in Mutare do not have money to cover medical bills let alone to acquire drugs from pharmacies. This concurs with Mosadeghrad (2014) who indicated that it is mostly the urban poor who cannot afford tertiary care services to access health care.

Another married male respondent of age range 46-55 interviewed perceptions on the state of health service delivery in the city had this to say:

Effective health service delivery in the city is a project that requires very expensive solutions during a time of limited governmental assistance in terms of monetary resources since as a result of political and economic meltdown, almost all the city health authorities in the country are suffering from budget deficits and inadequate financial resources for development, general administration, service delivery and infrastructural maintenance.

This clearly shows that it has been a long time since health service quality has declined in the city and that residents fear this may become the order of the day for life.

4.0 Conclusions

- Considering the study area, the researcher managed to establish that urban areas are facing many health delivery challenges. The failure to notice these challenges in the delivery of health services affects the lives of the urban inhabitants, rich or poor.
- Mutare city health officials are lacking the capacity to provide decent affordable health services to all its residents. Primarily this is because of financial turmoil and qualified staff due to the blanket freezes on employment of health personnel.
- There is a disparity in the access to health services between different income groups in Mutare as the poor tended to have lower levels of access get poorer quality of health services.

- Funding for health in the country is generally poor since is failing to meet the Abuja Declaration threshold which calls for 15% of the national budget to be allocated to the health sector.
- The country has experienced a worsening health crisis which is characterised by outbreaks of both communicable and non-communicable diseases including injuries especially in urban areas.
- The blatant corruption among city health authorities at all levels within their hierarchy is affecting the progress of the health services delivery. Misappropriation of funds contributed by donors, the government and rate payers are prevalent in the city health authorities and this greatly affects delivery of health services in the city.
- Public involvement is also a challenge thus beneficiaries are regarded as passive recipients of health services. Residents are unable to identify the role that they can play in the process of ensuring a well cherished health service delivery system.

5.0 Recommendations

- Clinics should be given resources to offer adequate quality maternity services for normal deliveries without charge, backed by improved referral along with waiting mother facilities at hospitals in order to reduce the maternal mortality rates in the city.
- Improved drug supplies are a priority for health workers and communities and therefore should be provided at primary care level to avoid people seeking care from higher level services at considerably greater distances, with higher costs to households and services. This means that the government should vigorously revitalise its primary health care (PHC) system as well as addressing the social determinants of health.
- To prevent further deterioration in the public health sector, government must give precedence to reducing the budget deficit and restructuring debt service. The government should at least meet the Abuja Declaration threshold which calls for 15% of the national budget to be allocated towards the sector or the WHO recommended minimum per capita expenditure of \$86. Until this has been accomplished, maximizing efficiency and redistributing available funding can do much to attain greater balance and effectiveness in service provision.
- Government must also take urgent steps to give priority to AIDS prevention, particularly to substantially augment the public and private resources devoted to behaviour change and mount an effective intersectoral response to the pandemic. The government also needs to come up with corrective taxes levied on goods and services that are considered bad for individuals or the society at large, such as tobacco and alcohol, in a bid to boost the Aids levy that was introduced in 1999.
- There is need to boost the number of Environmental Health Technicians (EHTs) and supporting them with resources (fuel, materials) that monitor, treat water and regularly collect refuse in and around cities.
- Local government revenue earmarked for waste collection should not be reallocated to other spending, and residents should be brought into monitoring waste dumping. Residents and business people can provide preliminary support with clean up campaigns, as Community Working Group on Health (CWGH) districts have done, but regular waste collection, water treatment services as well as more reliable provisioning need to be improved as a public health priority.
- A package of essential services as well as resources should be defined and casted at primary care level (including community outreach) and that a precedence should be given to ensure that this basic level of provisioning is funded and universally delivered by the entire providers of primary care clinic services

(central, local government, mission and other private) through budget, resource allocation as well as incentive mechanisms, monitored by communities, local government and health workers.

- Central government financing obligations to local government have to be clarified and constantly honoured so that services are not compelled to unfairly charge deprived communities in contradiction to national policy.
- Fee barriers at primary care services need to be removed since over 80% of the country's people live under the poverty datum line and are struggling to access health services.
- Financial mechanisms need to be set up for allocating, ring fencing and monitoring the resources for clinics as well as community health (given that it is currently buried in district budgets and managed at that level) that are acceptable and trusted by funders and communities.
- Logistics problems such as communication need to be addressed. There are opportunities for innovation: Cell-phones can for example be used for emergency or medical communications, for passing information, tracking services and reporting outbreaks, to update on drug stocks, orders, or through handheld personal digital assistants (PDA), to communicate data in the health information system. There are opportunities in this for moving away from old paper based health information data flows to less cumbersome electronic forms.
- Leaders throughout the world should live up to the pledges they made when they agreed to the Sustainable Development Goals in 2015 and ensure that everyone everywhere has access to essential quality health services without facing financial hardship.

Acknowledgements

Our special appreciation goes to Munashe Panashe and Tinashe Chikwature for giving us time for the successful completion of this study. Thank you to all who directly or indirectly contributed towards this milestone achievement.

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