Chapter 3
Public Safety and Health Systems in the Context of COVID-19 in Zimbabwe: Gaps and Prospects

Kelvin Zhanda

Abstract Until recently there has been a paucity of scholarly and policy attention given to public safety systems with respect to emergency public health disasters such as the novel COVID-19 in developing countries. The chapter explores and examines the institutional frameworks around public safety and health systems amid the COVID-19 pandemic in Zimbabwe with the aim of building safe and healthy societies. The chapter employed qualitative research paradigm utilising extensive review of secondary data sources. Thematic content analysis was engaged for data analysis. Results indicate that the possibility of public safety violations has depended on the impact of COVID-19 to the public health system and harshness of livelihood shortages during the lockdown period. Thus, the COVID-19 pandemic has become more of a public safety concern much than a mere health concern in Zimbabwe. While the Zimbabwean government operationalised the Civil Protection Act and instituted a number of COVID-19 containment measures (statutory instruments, plans and policies) backed by law enforcement, public health and safety agencies have neglected the firm integration of safety systems in their provisions. Given the need for law enforcement in a public health crisis, Zimbabwe law enforcement entities' conduct has, however, impacted on some public safety issues. As such, the chapter establishes the basis for recasting the public safety and health entities among other relevant multi-stakeholders as they interlink in enforcement of health-safety protocol and integrated public safety planning which is evidently absent in Zimbabwe as exposed by COVID-19. The chapter concludes that Zimbabwe needs public safety frameworks which are resilient and interoperable to strengthen health-safety systems' capacity through policy reforms for controlling pandemics to ensure safer communities.

Keywords COVID-19 · Policy · Public health-safety · Law enforcement

K. Zhanda (✉)
Department of Architecture and Real Estate, University of Zimbabwe, Harare, Zimbabwe

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3.1 Introduction and Background

The outbreak and subsequent spread of coronavirus disease 2019 (COVID-19) pandemic around the globe (Liu et al., 2022) has been anything but far-reaching threat to all facets of human life. According to the data from the World Health Organization (WHO, 2020b), as of 22 December 2020, 1.6 million deaths were reported globally. These statistics had increased to over 278 million cumulative cases and 5.4 million cumulative deaths worldwide as of 27 December 2021 (Liu et al., 2022). The fatal consequences of COVID-19 have compelled people to regularly take extraordinary safety precautions (Agojo, 2021: 363) aided by WHO's COVID-19 safety protocols such as quarantine or isolation of international travellers, widespread testing and tracing secondary contacts. Since the WHO, on 12 March 2020, declared COVID-19 a global public health emergency of high international concern (Liu et al., 2022), several countries all over the world have reacted quickly, instituting medical and non-medical interventions to prevent and reduce the rate of infections (World Bank, 2020). The main non-medical public and personal intervention measures (underpinned by laws of the states) included prohibition of public gatherings, travel curfews, the closure of non-essential services, social distancing, wearing of face masks and handwashing. These measures work hand in hand with medical resources such as ordinary hospital beds, intensive care unit beds, ventilators and health personnel (nurses, doctors, pharmacists) to ensure effective control (Liu et al., 2022).

In Africa, the first measures taken by governments were to restrict cross-border movement and limit air travel (Worldometer, 2020; WHO, 2020a) with South Africa being the first in sub-Saharan Africa (SSA) (Pearson et al., 2020). Governments began implementing measures in accordance with WHO guidelines to contain the spread of the virus since it became clear that the border closures were not effective. However, other scholars contend that such COVID-19 control measures presented challenges for many countries especially in SSA (Pearson et al., 2020) where overstrained health systems, vitiated critical infrastructure and poor public health surveillance affected their latent efficacy (Mackworth-Young et al., 2021). Zimbabwe is one of the countries plagued by COVID-19. As of 29 December 2020, the country had recorded 13,325 cumulative cases, 359 deaths and 11,067 recoveries (Worldometer, 2020). Despite Zimbabwe's poor public health-care system and emergency preparedness, the government pronounced a series of national lockdowns. The lockdown measures were put in place to flatten the COVID-19 transmission curve and to prepare the health system for management of the anticipated impact of the disease (Mhlanga & Ndhlovu, 2020).

The efficacy of the COVID-19 prevention and control measures is largely determined by other factors which are related to the country's ability to react to public health disasters (Liu et al., 2022), economic conditions and multi-sectoral approaches. For example, public safety and health security and gross domestic product can go a long way tackling a pandemic. Ramifications of 'shelter in home' measures in a country already experiencing socio-economic problems like Zimbabwe (Zhanda et al., 2022; Nhapi, 2019) have become unprecedented. Besides,

the negative approaches on fundamental human rights (Mavhinga, 2020), through, inter alia, convulsive responses by the law enforcement agents, and reduced access to basic needs such as food. Social distance and quarantining in the townships of Zimbabwe were seemingly a perfect fit of impossibility, and to enforce the COVID-19 containment regulations only appeared to worsen the situation (Zhanda et al., 2022). In the time of COVID-19 pandemic, public safety is a serious concern. As such, the activities that the public must carry out to safeguard and protect the mass population from harmful impacts of safety risk threatening behaviours (Al-Bsheish et al., 2021) are so critical.

Until recently, nevertheless, research in SSA has hardly explored and examined the interactions between public safety and health in determining safety and health outcomes especially in the times of pandemics and disasters. While there is growing body of studies profiling the impact of previous pandemics such as Ebola in West Africa (Boozary et al., 2014), severe acute respiratory syndrome in 2002, MERS (Snowden, 2019) and the ongoing COVID-19 pandemic on health-care providers, very few have delineated and investigated the impact of epidemics and pandemics on public safety institutions (Schweig, 2014). Since response measures are critical to health emergencies, Von Gottberg et al. (2016: 1) echo that contemporary studies on pandemic preparedness are mainly focused on health-care services. In the United States, the George Mason University's Center for Evidence-Based Crime Policy and International Association of Chiefs of Police started a partnership in March 2020 to conduct a multi-wave study so as to document the evolving impacts of COVID-19 on public safety and law enforcement agencies (Lum et al., 2020). Moreover, a global research study was conducted by Motorola Solutions in conjunction with Goldsmiths and the University of London to better comprehend how public safety entities around the globe adapted to overcome emerging challenges (Steinberg, 2021). The study found loopholes in public safety systems and ample evidence for the great need for innovation to ensure that people and property are safe and protected amid the COVID-19 pandemic. As such, Steinberg (2021) argues that the global pandemic has ignited a new era of public safety innovation.

Why would a pandemic like COVID-19 be a public safety question, as opposed to a mere public health problematic? In an attempt to address this research question, the present chapter presents the intricacies of safety and health, moving away from 'conventional' occupational safety and health but integrating other sectors and community participation. Maintaining adequate responsive capacity and functioning of health systems amid the pandemic depends largely on the functioning of critical infrastructure, which includes an array of national and municipal services ranging from public safety, emergency service, power and water supply, public transport, traffic surveillance and waste management (Itzwerth et al., 2006). There is an emerging recognition that the novel coronavirus is a public safety threat in developing countries particularly in Zimbabwe. The COVID-19 pandemic has posed a public safety risk in Zimbabwe. Being described as a 'global public bad' (Baldwin & di Mauro, 2020), the COVID-19 pandemic threatens public safety, and it means that any failure to curtail the virus threatens the safety of every citizen within the country. Amid the COVID-19 era, safety issues such as violence (Humphreys et al.,

2020), fire and robbery, among other crimes, were reported not only in SSA countries such as South Africa, Malawi and Zimbabwe (Newham & Du Plessis, 2020). However, while safety agencies were restrained by lockdown rules, their roles were compromised by a number of factors which include, inter alia, resources and human capital. To this end, law enforcers as safety agencies were called upon to enforce COVID-19 containment regulations such as lockdowns, social distancing, quarantines and proper wearing of face masks and to provide security in health centres full of COVID-19 patients, as well as ensuring that when vaccines became available in limited quantities, these could be distributed to the areas with the pressing need for them. These have also divided their attention, leaving gaps in the public safety fraternity. In order to contain the virus and address its devastating secondary effects, multi-sectoral action is needed, roping in, inter alia, public safety in focus.

Yet, in direct contrast to the Zimbabwe national COVID-19 responses that have been taken, far less has been considered about public safety challenges exhibited in policies and plans (see MoHCC, 2020). Notably, public safety and fundamental human rights are interlinked (Caruso, 2017). This entails that the violation of human rights through health governance interventions amid the COVID-19 pandemic has impacted on public safety. A selected number of the measures taken to fight the COVID-19 have been considered extreme as they encroached on basic human rights (Mavhinga, 2020). These include rights such as right to education and freedom of assembly and movement, halting various cultural and religious activities. Regardless of the complexity of pandemic environment, the lockdown regulations were still supposed to be reasonable and proportionate (Maulani et al., 2020). The continued rise of public safety concerns amid the COVID-19 has stirred public health policy responses that are alive to the concerns of the community besides having another problem at hand. Like elsewhere across the globe, if Zimbabwe wants to flatten the curve of the pandemic and protect lives, it needs to speak to the safety of the people in the country, including vulnerable communities.

In line with these perspectives, the present chapter explores the intricacies between public health and public safety, paying specific attention on how public safety systems and approaches vis-à-vis public health responses affect health and safety outcomes amid pandemics. These arguments draw on research from the public health, public safety and public policy circles, and the study will deliver an array of practically feasible propositions for implementing the public health-safety model. Specifically, this discourse's primary purpose is to present and examine various ways in which public safety and public health agencies in Zimbabwe have responded to the COVID-19 pandemic and how best the country can learn from its 'undoing' so as to aid its communities' resilience to safety and health problems now and in the future. The chapter explicates the role of the community, security departments and public safety and health entities as they interlink in enforcement of COVID-19 containment directives and with various stakeholders' responses to COVID-19. The basis for which public health and public safety institutions in Zimbabwe should respond to the health and/or other national crises was thus laid. This scholarly work contributes to the field of public safety and health and emergency management by enhancing public safety and health system preparedness and response challenges,

which were unknown concerning the response measures to biological hazards and disasters. Through gaining the safety preparedness perspectives, experts in public emergency situation and response (Hooper, 1999) will then serve to shed light on the public safety and health field as to what risks and preparatory requirements are associated with pandemic response. Therefore, the chapter builds a basis for an integrated public safety planning and development which is evidently absent in Zimbabwe. The chapter recommends public safety frameworks which are resilient and interoperable to strengthen health-safety systems' capacity through policy reforms for controlling pandemics to ensure safer communities.

3.2 Conceptualising Public Safety-Health Systems

While there are a number of crucial links and similarities between public health and safety (Caruso, 2017: 2), it is important to start conceptualising them separately in order to bring an understanding of their nexus in a public crisis like COVID-19. Nevertheless, while there are various ways of defining public safety and different scholarly accounts of what public health intends to achieve, what is clear is that both are primarily prerogatives of the state. For years, public safety has been understood to be the first duty of government by policy- and decision-makers (Friedman, 2021). Friedman (2021) posed three critical questions: But what is meant by 'public safety'? What precisely does it entail to be safe? And more to the present point, what is required as part of government's obligation to assure that each and every one of us is safe? One might think, probably, that the questions themselves make a fetish of a term: what can it possibly matter if something is viewed as 'public safety' or 'not public safety'? Friedman argues that the answer to the first question (what is public safety?) may seem plain, evident even, but it is not. Public safety was also seen as an umbrella term under which social and situational approaches could not be juxtaposed but rather fused.

At the same time, events such as the economic turmoil it has unleashed, rising homicide rates in major cities, terrorism, widespread protests over police violence supported by demands to defund the police (Richards et al., 2006) and the current COVID-19 pandemic all underscore the importance of answering the question correctly. At the centre of public safety are the concepts of 'protection and security'. Conceptually, the term 'public safety' was used interchangeably with 'crime prevention'. Even so, the latter was viewed to be overly narrow and closely associated with police-related duties and responsibilities (Crawford, 2002).

Since issues of 'protection and security' are at the centre of public safety, scholars have tended to define public safety rather narrowly, largely in terms of the 'protection' role, that is, protecting people from violent harm to property or person from natural elements and third parties (Friedman, 2021). But, is protection really all there is to public safety? There are extensive harms that can occur by narrowly focusing on public safety as protection and also neglect all the other elements of human safety. For many people, being safe depends on the sufficient availability of

food, clean water and air, housing, a basic income and the means to acquire it, a job and education (Friedman, 2021). It might also include health insurance, health care and freedom from discrimination. Arguably, if public safety includes one or all of these elements, then public safety as the government's obligation to ensure people are safe should be understood more broadly than it is in present years. Thus, public safety needs to expand to include many of the other circumstances that threaten individual safety beyond violent harm. When public safety is deliberated in the public domain, it typically has been assumed to mean freedom from violent and physical harm and injury to one's person and to one's property, in particular from violent crime or events (Steinberg, 2021). Certainly, and nonetheless, people also do not feel safe if they are forced to sleep on the streets and to forage in trash cans for food or are facing starvation. If they are lacking an education and cannot earn a living or find a job, they do not feel safe if they are confronting grievous illness or if they face health-care costs they cannot afford (Friedman, 2021).

In America, for example, it was the conclusion that government had failed the people of Flint, Michigan, in its obligation to provide them clean water; government conceded as much (Crawford, 2002; Friedman, 2021), and the government similarly was understood to have failed in the time it took to restore power to the people of Puerto Rico following Hurricane Maria. Therefore, governments across the globe by common consensus are responsible for addressing the COVID-19 pandemic which is currently affecting people. But how far should the governments' duty to provide public safety extend? If clean water does, it also includes clean air? If electricity, what about food or housing or education and job opportunity for that matter? If fighting COVID-19 pandemic, what about health care in general? These questions bring to light the importance of understanding the inexorable linkages of public safety and health systems as they interlink in policy and practice during public health emergency.

Public safety governance is quite complex given its embodiment of many institutions (Friedman, 2021) and a myriad of sustainable human development inputs (WHO, undated) such as health, human security, livelihoods, education and governance (see Fig. 3.1). Thus, public safety knows no physical boundaries as it has affected rural and urban enclaves throughout human history. However, the rate at which they have been affected has increased mainly as a result of a number of factors that include poor civil protection governance frameworks, lack of political will, corruption and the decay of social capital (Crawford, 2002). From 1993 to 1999, the average safety violations recorded were 428 per annum, but this figure had increased to an average of 707 of such events per year from 2000 to 2004 (Crawford, 2002). This highlights how both the rural and the urban environments, especially in low-income countries, are subject to a number of safety risks and hazards. Public safety problem originated from a series of emergency activities in the face of social activities and crises (Crawford, 2002) and lack of emergency and disaster preparedness (Hooper, 1999). Figure 3.1 illustrates that public safety is multidimensional, and as such, it calls into focus system approach to ensure communities are safe during a pandemic. This signifies the problems faced during the COVID-19 pandemic across the globe.

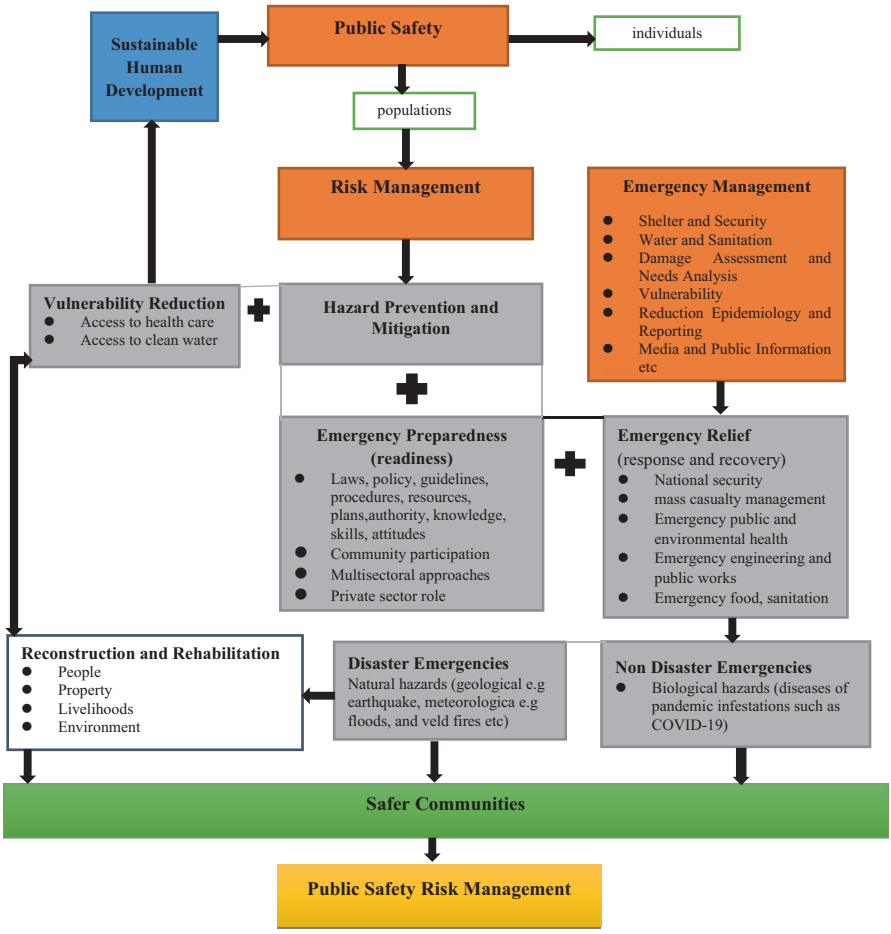

Fig. 3.1 Public safety framework. (Source: author's creation, data based on WHO (undated))

According to Faden and Shebaya (2015), public health has four distinct characteristics: (i) it is a public or collective good; (ii) its promotion involves a particular focus on prevention; (iii) its promotion often entails government action; and (iv) it involves an intrinsic outcome orientation. These characteristics can equally be applied to the concept of public safety. First, in public health, the object of concern is populations not individuals. Thus, public health is, by its very nature, a public, communal good, where the benefits to one person cannot readily be individuated from those to another (Faden & Shebaya, 2015). One can say the same thing for public safety – it too is a communal good. The societal goods we seek in the safety and criminal justice system such as safety, security and justice are aimed at the collective good, and the policies employed to achieve them are designed and implemented with the public good in mind (Caruso, 2017). Some of these may be part of the public safety and health that national governments must provide, and some may

not. Therefore, until authorities rethink what constitutes safety, it will not direct them more sufficiently.

The rethinking of concepts of public safety and public health particularly in the purview of their connection and implementation from policy to practice are decisive in rallying public health and safety entities to incorporating both concepts into the recuperation process as well as reshaping the health emergence philosophy of the country (Snowden, 2019). This binds that public safety-health is an ongoing requirement for many countries across the globe, which should be the top priority due to increasing dangers to the communities, the environment and its people (Richards et al., 2006). Therefore, in some countries, local institutional responses have taken place within programme and policy frameworks amid the COVID-19 pandemic that aim at coordinating contributions by health agencies (Maulani et al., 2020) and safety agencies from both the private and state circles. However, exposure and risk to infectious pandemics or diseases and its implications are determined by the size, age and level of operational and financial sustainability of the country's public health and public safety institutions.

3.3 Safety Systems and Health Systems in Zimbabwe: An Overview

This section presents contextual premises upon which the study on implications of pandemics like COVID-19 on the public safety and health systems in Zimbabwe can be built upon. Studies on public safety in Zimbabwe are very limited, and as such, it is of scholarly interest (Crawford, 2002) for this chapter. The existing public safety institutions are mandated to maintain their operations so as to ensure the safety of the communities they are obligated to serve (Ministry of Local Government, 2009) at law. Unlike South Africa which has the Public Safety Act, Zimbabwe has no specific legal statute on public safety to govern the operation of all safety agencies in the country with the ultimate goal of maintaining people's safety nationwide. According to Section 219 of the Constitution of Zimbabwe Amendment (No. 20) Act of 2013, the Police Service is responsible for *protecting lives* and property of the people, maintaining law and order, enforcing and upholding the law and preserving the internal security of the country (GoZ, 2013). Law enforcement services to maintain law and order, protect the public and property as well prevent crimes are provided by the Zimbabwe Republic Police (ZRP) housed under the Ministry of Home Affairs and Cultural Heritage. The same legal document, Section 213 subsection 2(b), outlines the deployment of defence forces in support of the ZRP and other civilian authorities in the event of an emergency of disaster (GoZ, 2013).

In addition, public safety and civil protection systems in time of disasters are premised on the Civil Protection Act (CPA) of 2001 (Chapter 10:06). The CPA establishes a civil protection organisation (CPO), a national platform comprising of line ministries, state enterprises, private sector and NGOs whose regular activities are related to emergency responses (Ministry of Local Government, 2009). The

CPA directs every district and province to have responsibility for the protection and preservation of the lives and property for their citizens. The responsibility for the implementation of the CPA lies with the Department of Civil Protection (DCP), which falls under the Ministry of Local Government. DCP provides guidance to the state and downwards in dealing with emergencies and disasters as well as physical assistance to areas that fail to cope in an emergency (Department of Civil Protection, 2012). The DCP is supported by the Commissioner of the ZRP, Zimbabwe Red Cross Society, Secretary of the Ministry of Health, the fire brigade, military commanders, Director of Prisons and Director of Civil Aviation. These can appoint subcommittees, though not clear in the CPA, drawn from government line ministries and NGOs (Mavhura, 2016). These include, inter alia, the Zimbabwe National Water Authority, Zimbabwe Electricity Supply Authority and United Nations (UN) agencies such as UN Development Programme, International Organization for Migration and NGOs such as Zimbabwe Red Cross Society, Save the Children, Oxfam GB and World Vision (Mavhura, 2016). The functions and roles of these entities are critical for underpinning citizenry safety in the country.

Zimbabwe's present health-care delivery system can be simply described as 'weak and unsafe'. Talking of achieving universal health coverage, the central pledge of the United Nations' 2030 Agenda for Sustainable Development (UN General Assembly, 2016) in the commitment to 'leave no one behind', Zimbabwe is not anywhere close to meeting the target. Zimbabwe initially got off to a good start following independence, with the 1980s witnessing several positive gains in health service delivery (Nhapi, 2019: 161). Health institutions were strong as they facilitated 'health for all' policy with massive health infrastructure and health services spread to within reach of the vast majority of the population, even in rural areas (World Bank, 1992). In the 1990s, however, increasing professional and public anxiety over declining quality, equity and access in health services and increasing demands on people to pay out-of-pocket for professional care were witnessed (World Bank, 1992). The public health system of Zimbabwe is comprised of the seven tertiary care institutions (provincial hospitals), 1331 primary care institutions (rural health centres and clinics), 179 secondary care institutions (district and missionary hospitals) and 14 quaternary care institutions (central hospitals) (Tren et al., 2007).

Notably, even prior to the outbreak of COVID-19, Zimbabwe's health sector was precarious, under-financed and understaffed (Maulani et al., 2020). Access to specialised care is highly unequal, exemplified by the common practice of African elites seeking health care abroad (Nyazema, 2010). As of 2017, Zimbabwe's health system was battling with quite a number of diseases as patients succumbed to treatable diseases such as malaria, cholera, typhoid and other cardiovascular ailments. While health indicators such as life expectancy, morbidity and mortality have relatively improved over the past two decades (Maulani et al., 2020), other health threats such as child mortality, maternal health and malaria, tuberculosis, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other elementary health services remain a challenge to date (Nhapi, 2019). Overall access to quality health services, however, is very low, especially in remote areas of

the country. Zimbabwe has a total number of 214 hospitals (public and private) out of which 120 are government hospitals to serve a population of over 15 million people (Mackworth-Young et al., 2021). WHO (2020b) reports a huge doctor to patient ratio with an estimated 7200 nurses and 1600 physicians for every 10,000 people and a health sector vacancy rate of over 50%. Mackworth-Young et al. (2021: 85) observe periodic work stoppages by health-care workers protesting against under-resourcing of Zimbabwe's health system and meagre salaries. This further restricted the health sector's capacity and resilience to respond to the health disasters such as cholera and COVID-19. The outbreak of Ebola health crisis in West Africa, for example, had showed the fatal repercussions (measured in mortality rate) of a public health crisis under a health system deficient of resilience are significant (Boozary et al., 2014). This situation has not been peculiar to Africa only as was the case in Italy's Lombardy region where the health-care system was strained from COVID-19 to the extent that authorities were asking retired doctors to come out of retirement and student nurses fast-tracked to graduation (Al-Arshani, 2020). Zimbabwe also lacks amply accessible health insurance which translates to mean that the majority of people have no medical aid (Nhapi, 2019).

While the public sector provides 65% of health-care services (Nhapi, 2019; Tren et al., 2007). Zimbabwe's funding of the health sector has been stalled mainly by the plummeting economy characterised by hyper-inflation, over 90% unemployment rate (Mukoka, 2020), corruption, poor public service delivery and poor, if not inconsistent, policies in resource allocation. This leaves many countries in the Global South's health systems unprepared for tackling respiratory health problems. As such, health systems mainly in Africa have been plagued, yet health experts advised that an extended COVID-19 pandemic would engender numerous hospitalisations, which would seriously strain the health systems' capacities (WHO, 2020b) of the countries. Unsurprisingly, Zimbabwe has struggled to produce and acquire COVID-19 testing kits, ventilators and necessary personal protective equipment (PPE) (Muronzi, 2020). Thus, COVID-19 cases and fatalities in Zimbabwe were recorded. At the centre of these problems, one would anticipate that the government must respond in a way that strikes a balance of safety systems and health of the communities.

The threat of COVID-19 on health systems in low-income countries could be exemplified and exhibited by the crisis faced by high-income countries in the United States, Asia and Europe (Jennings & Perez, 2020). Therefore, if developed countries with state-of-the-art health facilities and adequate funding were severely affected, the worst could be expected for developing countries, particularly those already suffering from the same challenges faced by health systems in Zimbabwe articulated in the preceding paragraphs. This, therefore, means the danger of a potential spread of the COVID-19 in Zimbabwe could spell a public disaster of unprecedented degree.

3.4 Methodology

A qualitative paradigm was employed for this chapter, which mainly utilised secondary data sources. According to Teti et al. (2020), qualitative methods are crucial in deciphering public health disasters like COVID-19, its impacts on humans and subsequent responsive strategies. The chapter aims at providing guidelines for public safety and health risk assessments and implementation of preventive and protective measures. As such, the chapter engaged qualitative paradigm to provide explanations on how Zimbabwe has been coping to the COVID-19 pandemic focusing mainly on the nexus of public safety and public health systems. The collection of relevant data was done through extensive document review and scanning of various literature sources. Therefore, a desktop review was used to collect data. Secondary data sources such as books, journal articles, press publications and reports were used. Data from applicable literature and documents were reviewed in order to understand public safety and health agencies' position during the COVID-19 pandemic.

A large number of reviewed literature were published recently, between 2016 and 2022 ($n = 65\%$ and $n = 35.8\%$), directly focused on the COVID-19 pandemic. The author collected and reviewed over 89 documents. Of these, >80% were published peer-reviewed scholarly articles, 17 (2.8%) were government documents, 12 (7.1%) were from non-governmental organisations (NGOs), and 2.1% were from the press. The Zimbabwe Preparedness and Response Plan, Statutory Instruments. The chapter was also woven using empirical data constructs obtained from the World Health Organization Statistics and Africa Centres for Disease Control and Prevention (Africa CDC).

Literature review was done on thematic topics that identify the effects of COVID-19 on public safety and health agencies among other first responders to decipher the implications of the pandemic on the safe and healthy Zimbabwe society. The author identified areas of key interest that are related to public safety and health (public safety and health institution, first responders). These areas involve safety risks, public health mandates, demand for public emergency services, demand on crime, liveability exposure, PPE availability and use, communications, public health and safety and human resources. Each of the topics intersected with different unmediated and mediated effects on public safety and health players. This research approach had a few limitations concerning the scope of the study and, perhaps, comprehensiveness. The chapter relied on data researched between March 2020 and late November 2021. However, new research will continue to emerge (Zhanda, 2020) on the impact of the interface of public safety and health amid COVID-19. The research focuses on enforcement (police), and emergency medical services, and also accounted for other entities which provided services during the COVID-19 pandemic such as emergency departments, corrections, courts and security.

Data were classified into themes, and thematic content analysis was engaged in analysing the data and to draw meanings from it. From literature, key public safety and health concepts alongside some COVID-19 themes were selected to figure the

content of literature to be analysed and reviewed. Synthesis was conducted from the themes, and conclusions were drawn. The limitations of the study are that findings on the gaps and prospects of the public safety and health systems amid the COVID-19 pandemic may not be directly generalised to other countries in the Global South and beyond. However, important lessons can be drawn and go on to influence policy. Findings from the study on the experiences and public safety-health in Zimbabwe can be applied and generalised to other countries in sub-Saharan Africa and beyond.

3.5 Results and Discussions

3.5.1 State of Public Emergency

On 11 February 2020, the World Health Organization (WHO) officially declared COVID-19 a worldwide pandemic rendering it a public health emergency of international concern (WHO, 2020b). The International Health Regulations (IHR) adopted by the World Health Assembly in 2005, which are binding on all WHO member states, provide a regulatory framework for international management of public health emergencies (WHO 2008).

In accordance with the legal obligation imposed on each member state to notify WHO of events that may constitute a 'public health emergency of international concern' within its borders (WHO 2008), the government of Zimbabwe notified WHO concerning these developments (MoHCC, 2020). As a critical step to ensure public safety and safeguard public health and battle COVID-19, the *President of Zimbabwe* made a declaration on 23 March 2020, under the Civil Protection Act, that a state of disaster existed across Zimbabwe with immediate effect (MoHCC, 2020). Such declaration of state of disaster is clearly set out in Section 27 of the CPA which gives the President power to declare state of emergency if any disaster of a nature and extent that require extraordinary measures to assist and protect the persons affected or likely to be affected by the disaster in any area within Zimbabwe.

Through the Statutory Instrument 76 of 2020 on Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe) Notice 2020, COVID-19 was declared as a national disaster (GoZ, 2020) and a national lockdown for 21 days was announced on the 27th of March 2020 through the (COVID-19 Prevention, Containment and Treatment) (National Lockdown) Order, 2020 contained in Statutory Instrument 83 of 2020 declared national lockdown except for essential services and exempted cases for a period of 21 days (see https://www.veritaszim.net/node/4072). This was accompanied by the Public Health (COVID-19 Prevention, Containment and Treatment) Regulations 2020 published as Statutory Instrument 77, 2020, made under the Public Health Act (see http://zimlii.org/zw/legislation/si/2020/99) that declared the disease a formidable epidemic disease. These legal instruments have led to the setting up of public safety and health machinery in the form of various arms of the state such as the Zimbabwe Republic Police (ZRP), for purposes of containing COVID-19 health emergency and its concomitant problems.

Moreover, channels were open towards the mobilisation of resources necessary to battle the disaster as well as to provide governmental support to affected and vulnerable communities. The 'legal' response to the pandemic shows the efforts to protect the citizens.

3.5.2 Public Health Systems Amid COVID-19

Although the field of medicine is important in the detection, prevention and treatment of COVID-19, health crisis control frameworks in Zimbabwe are grounded on public health principles and regulated by public health law. Under the Zimbabwe Public Health Act, there are a number of legal provisions dealing with infectious diseases and powers to manage (control and prevention) formidable diseases, many of which have been engaged in the COVID-19 containment orders. In line with the WHO obligation, Zimbabwe's health institutions supported by the government have developed, strengthened and maintained its national capacity to detect, assess, report and effectively respond to public health disasters and risks (WHO 2008). The public health approach to COVID-19 in Zimbabwe has been spearheaded by the Ministry of Health and Child Care (MoHCC) providing much-needed technical support to all sectors of the economy, communities and health-related institutions. While the basic public health strategies in response to diseases such as COVID-19 traditionally focus on prevention, control, testing and surveillance (MoHCC, 2020), the MoHCC adopted a timeline of priority activities centred on infection prevention and control (IPC) and policies and standard operation procedures.

3.5.3 Public Safety and COVID-19 Pandemic

The COVID-19 pandemic has shown the critical and necessary role of public safety institutions (PSI) as 'first responders' in protecting all Zimbabweans from public safety risks. Public safety risk is a biological hazard proportional to vulnerabilities and preparedness (WHO, undated). Hence, COVID-19 can be classified as a biological hazard. Perry (2007) regards a hazard as a determinant of the types of risks such as disease and death. Vulnerabilities or readiness are determinants of how much risk (risk modifiers) and determines pre-impact risks and preparedness determines post impact risks (Perry, 2007). While Civil Protection Planning Committees must be established under the CPA to enhance preparedness, it has not been possible to observe if any such committees have been established. Public safety risks in Zimbabwe during the COVID-19 pandemic can be viewed as the potential outcomes from the exposure of communities to COVID-19 biological hazards. According to Perry (2007), public safety risks are reduced by minimising exposure to hazards through mitigation and prevention, reducing vulnerabilities of people, livelihoods, property, environment and services and increasing preparedness of responders.

PSI which fall into the civil protection system of Zimbabwe (Ministry of Local Government, 2009) which include professionals striving to ensure the safety and security of citizens have been given leeway to operate under the COVID-19 restrictive measures. These include police (national and municipal), firefighters (occupational and voluntary), national border officials, public safety communicators, correctional services officers and paramedics. PSI around Zimbabwe have responded to COVID-19 in several ways, such as public campaign awareness about the coronavirus. At the outset of the COVID-19 pandemic, safety agencies had promptly responded to COVID-19, with the majority receiving some kind of guidance and training on the PPE to ensure safety of officers. As elaborated earlier on, the Zimbabwe Republic Police (ZRP) is one of the critical stakeholders within the country's public protection and security architecture, and its resilience amid the pandemic matters most to the safety of people across the country. The ZRP facilitated the COVID-19 exemption letters. The ZRP was supported with local authorities as the Morgan Report in 1990 in the United States, for example, advised that local government authorities should be provided 'statutory duties' for crime prevention and, collaborating with the police, for promotion of public safety (Jones et al., 2020).

Public safety risks in Zimbabwe amid the COVID-19 crisis could be understood by exploring the impact on PSI and the recipients of safety services, the public. Prior to the COVID-19 pandemic, PSI reported a number of occupational stressors which include insufficient resources. Casoni (2019: 1) observed that in past events, disaster relief and public protection institutions, such as ambulance service, fire brigades and the police, have always had many challenges to effectively carry out their work owing to organisational and technical bottlenecks. Hence, deadly COVID-19 pandemic challenges, such as the risk of personal and familial contagion (Mbulayi et al., 2021), have somewhat further intensified strains on PSI. This stresses out that appropriate measures and risk assessment must underpin primary prevention of COVID-19 among individuals, workers and businesses. Other risks intensified by COVID-19, such as harassment, discrimination and violence (Zhanda et al., 2022; Humphreys et al., 2020) stigma, and protracted use of personal protective equipment (PPE) have been observed. These have posed public safety concerns.

The Zimbabwean central and local governments have been at the front line of ensuring that the public is safe. While public safety entities have the obligatory duty of managing crises (natural and man-made), the rate and impact of COVID-19 required attention to crafting crisis and emergency management plan of action while also acquaintance necessary community services. The general public, consumers and workers were protected. Citizens should continue to enjoy their right to healthy and safe living conditions in the context of COVID-19. Nevertheless, the ongoing COVID-19 pandemic has imposed financial and human costs on public safety and health entities that risk exposure to the pandemic. Table 3.1 uses the WHO public safety emergency and risk management framework to measure or assess the reported COVID-19 response progress by the Ministry of Health and Child Care (2020) and other related entities in line with the goal of ensuring the health and safety of people amid the COVID-19 pandemic in Zimbabwe.

Table 3.1 Scores of public safety in Zimbabwe during COVID-19 pandemic

Public safety emergency and risk management	Scores of reported progress
Damage assessment and needs analysis	Assessments of status of preparedness of major isolation health facilities and points of entry, February 2020
Epidemiology and reporting	Epidemic preparedness and response task force Zimbabwe's national preparedness and response plan for COVID-19 of 2020
Mass casualty management	Designation of isolation hospitals at Thorngrove (Bulawayo) and Wilkins (Harare) infectious Diseases hospitals
Hospital planning	Wilkins hospital renovations for containing COVID-19 patients Expand testing capacity to National Virology Laboratory and Mpilo central hospital Support hospitals to develop business continuity plans
Curative care	COVID-19 vaccines
Shelter (place of safety) and security	Nothing recorded
Water and sanitation	Promote access to water and sanitation in public places and health facilities Monitor infection prevention and control and WASH implementation in health-care facilities
Control of communicable disease	Infection prevention and control Policy and plan (see Zimbabwe guidelines for the management of COVID-19, 2020) Personal protective equipment (COVID-19 PPE Policy 2020), COVID-19 control regulations and law enforcement
Food and nutrition	Nothing recorded
Reproductive health	Nothing recorded
Psychosocial needs	Nothing recorded
Medical supplies and logistics	Develop chops for logistics, procurement and supply management Carry out inventory of all supplies based on WHO package of commodity Form central stock reserve of essential medicines, vaccines and supplies Weekly meetings of logistics thematic technical department
Media and public information	Information dissemination COVID-19 campaigns COVID-19 hotline call 2019

Source: Author, data from WHO (undated); MoHCC (2020)

3.5.4 Public Health Systems and Public Safety Systems: Nexus

The COVID-19 pandemic has confirmed the fact that public safety and public health are natural allies. Promotion of public safety amid the pandemic espouses itself fittingly with a public health approach for various reasons as it shares many of the special characteristics of pandemics (Schweig, 2014). Public safety institutions in Zimbabwe have been working alongside public health-care officers and have proven to be critical for curtailing the COVID-19 pandemic. The health system has

indispensable and persistent obligation to people for their entire lifespan. It is important to healthy and safe development of individuals, households and the society. Therefore, health care is an applicative and tangled issue requiring extrinsic thinking beyond the health parameters of the present pandemic per se. The health system crisis is just one of the many threats Zimbabwe is facing during the COVID-19 pandemic. Despite having experienced disaster events such cholera and tropical cyclones in Zimbabwe, public protection and disaster relief agencies which include the police, ambulance service and fire brigades have always had a number of challenges to efficaciously conduct their work due to structural and technical and issues.

Poor-resourced public protection and safety systems in Zimbabwe have been much confined to work-related safety issues than to public health issues. It emerged that the expansion of environmental health services during the coronavirus crisis through the enforcement of laws for safe water, sanitation and hygiene has not been given the same emphasis with the 'safe workplace' dictum. As such, the COVID-19 pandemic has become more of a public safety concern much than a health concern in Zimbabwe. Despite the relative safety to humans' lives and possessions and the rising aggregate crime rates experienced across Zimbabwe amid the pandemic, governing threats to personal human safety and social order have become huge governmental preoccupations. These, however, should be a focal point for policy responses and attention, activities and actions towards the coronavirus situation in the country. Nevertheless, the fears born and fed by subjective and existential safety voids and insecurities have become very genuine in their consequences (Muchena, 2020).

In terms of public safety and health risk assessment, the potential effects for the public can be determined by their vulnerability context. In this regard, public safety officials in consultation with health personnel, and with support from infection prevention and control experts, should regularly conduct a community safety risk assessment for COVID-19. The goal would be therefore to determine the level of risk for potential exposure related to various safety violations and to plan and implement adequate measures for risk prevention and mitigation. The challenge is that health entities have less authority and often difficult processes to agree on what or whose public safety 'orders' to abide by. This raises questions on the risks from coordination problem with serious health and public safety overtones in the country. In terms of coordination between public and private actors via an emergency response mechanism, it appears there is no lucid reference to coordination with private players in the COVID-19 prevention regulations. Interoperability among the agencies to firstly respond belonging to contrastive players has also become very difficult and coordination actions among the agencies. Moreover, refurbishment and management of overburdened telecommunication infrastructure has become a major issue though it boosts technical responses to the COVID-19 pandemic, especially given the coordination gaps between public safety and public health institutions in Zimbabwe.

3.5.5 Law Enforcement and COVID-19 Pandemic

There are clear links between law enforcement and public health (Jennings & Perez, 2020) as the law enforcement agencies are obligated to work with public health agents to curtail the spread of the disease, serve communities and ensure public order. However, law enforcement officials have not deliberated about the ramifications of a type of public disaster that could devastate public safety agencies' operations (Laufs & Waseem, 2020). There has never been an expedient time than the current to examine the short- and long-term effects of the COVID-19 pandemic on law enforcement in Zimbabwe and to unravel law enforcement's conduct and ongoing strategies being implemented to ensure public safety and flatten COVID-19 as well minimising health risks of law enforcement officers.

Enforcement of COVID-19 mandatory orders has brought connotations on public safety and health systems. As explained in the foregoing sections, the government of Zimbabwe has taken emergency interventions to protect its mass population and slow the spread of the virus. Measures and regulations including lockdowns, social distancing and travel restrictions required the role of law enforcement agencies. This is ultimately supported by establishing legal penalties for violations of the regulations (Friedman, 2021). Since the initial lockdown in March 2020, law enforcement agencies, which are part of public safety agencies, were working together with the government (central and local) and public health officials to curtail the spread of COVID-19, serve local communities and maintain public safety. The ZRP (see www.zrp.gov.zw) and ZDF spearheaded the enforcement. As provided for in the Zimbabwe's Civil Protection Act, the ZRP in conjunction with the ZDF were given authority within the national COVID-19 pandemic response apparatus to do so. The ZRP, through a joint venture with the ZDF, has embarked on community patrols and roadblocks to enforce COVID-19 preventive and control measures. The ZRP ensured that public gatherings except funerals are prohibited and compliance was observed as well as facilitating COVID-19 essential services exemption letters. The ZRP has conducted community outreach initiatives, reassigned personnel to COVID-19 hotspot areas, implemented safety precautions for its officers as well as restricted access to its offices (Ntali, 2021). Thus, the law enforcement officials have been challenged with balancing the regular duties of maintaining public safety and order with the urgent need for emergency responsiveness to COVID-19. As experienced in countries such as South Africa (Newham & Du Plessis, 2020), this has created additional service burden and need for law enforcement institutions. This sits at the top of police services as the ZRP officers are expected to preserve public order and continue community policing operations though under a greater strain on resources.

The COVID-19 pandemic has also uncovered some significant barriers to law enforcement, pertinent to public health regulation enforcement and, ultimately, overtones on public safety. Zimbabwe law enforcers are no exception because they were faced with a number of challenges. Given the risk of COVID-19, enforcement agencies were at the high risk of contracting the virus. In light of a situation like

this, the Africa Centres for Disease Control and Prevention (Africa CDC) have urged law enforcement agencies to protect the public and officers. Although law enforcement agents have played a pivotal role, Mackworth-Young et al. (2021) have called into question their professional conduct to ensure that the public is safe amid the COVID-19 pandemic. In a pandemic, the conduct of control and prevention regulation enforcers is important. Organisations such as the Zimbabwe Peace Project have accused the law Zimbabwe's enforcement agents of selective enforcement of the law (Maulani et al., 2020). The law enforcement agents were observed not abiding by social distancing and wearing face masks, which is thus a public health-safety concern (Mavhinga, 2020). These challenges have been aggravated by the fact that the authorities were bemoaning shortage of resources in fighting the pandemic (Mackworth-Young et al., 2021).

In a pandemic like COVID-19, resources for law enforcement will quickly become engulfed (Lum et al., 2020; Laufs & Waseem, 2020), and law enforcement agencies like the ZRP will then need to balance their operations and resources between the emerging public duties and routine service demands. This has highly demanded technological innovation which is highly required in public safety during times of public emergency (Steinberg, 2021). Frontline agencies in law enforcement and emergency response needed to adapt quickly to meet the health security and safety needs of the communities they serve. Newham and Du Plessis (2020) argue that the ability of law enforcement agents to ensure public safety and maintain order during the lockdown depends on their rapid preparedness for a new mission. This is particularly important because the responses needed to be accomplished with much diminished personnel, as the ZRP officers and their household members might become infected which then compromise the health and safety of the public. In other instances, however, as observed by Laufs and Waseem (2020), some police workforce may consider that the risk of continuing to report to their work offices is just too colossal to their families and themselves.

3.5.6 Crimes and Safety of Individuals and Property

Crimes threaten safety and health of the public especially during a period of pandemic (Schweig, 2014). The lockdown measures in Zimbabwe have had direct impact on a number of criminal activities and organised crimes, which have stopped, slowed or increased. Although authoritative conclusion on the impact of COVID-19 control measures on public safety may be affected by the dynamics of the virus, Newham and Du Plessis (2020) reported that restrictions of public movements have yielded some safety outcomes.

Zimbabwe has faced different crimes during the lockdown period. The ZRP has recorded a decline in criminal cases between 30 March and 15 April 2020, mainly owing to the heavy presence of law enforcement agents across the country (Nemukuyu, 2020) especially in urban areas. According to the crime statistics, the ZRP recorded 27 murder cases between 30 March and 15 April 2020, whereas 46

cases were reported during the same period in 2019 (Nemukuyu, 2020). Moreover, 65 planned robberies were reported across Zimbabwe in the first 17 days of the lockdown, a lesser figure compared to 150 cases reported to the ZRP in 2019. The ZRP also received two cases of motor vehicle theft in the first 17 days of the lockdown, while five cases were reported during the same time last year. As reported by Nemukuyu (2020), the ZRP Assistant Commissioner explained that due to lockdown, people are staying safely at home protecting their properties. The presence of police officers and the military in communities has reduced crime rates, and many roadblocks worked to ensure that stolen items cannot pass through roadblocks undetected.

However, the COVID-19 pandemic-induced lockdown has come with it organised crimes on robbery, theft and property crimes. Incidents of violence, especially family violence (Zhanda et al., 2022), as well as alcohol and drug misuse were intensified. Zhanda et al. (2022) observed a 36% increase of domestic gender-based violence, lack of household peace and instability in Zimbabwean urban areas such as Harare and Gweru owing to lockdown measures. However, due to the victims of violence's inability to report to the police stations due to lockdown (Zhanda et al., 2022), the ZRP recorded only 193 domestic violence cases between 30 March and 16 April 2020, a decrease from 678 cases in 2019 (Nemukuyu, 2020). Zimbabwe is battered by socio-economic and governance factors signified by the Zimbabwe Vulnerability Assessment Committee of 2019 and the International Poverty Line, which reported a parity index of US$1.90 with 5.5 million people in rural areas and 3.9 million people in urban areas regarded as food insecure (Zhanda et al., 2022: 9). Confining these poor households under lockdown for months has compounded tensions among people leading to incidents of domestic and sexual violence (Zhanda et al., 2022). This can go a long way in negatively affecting the safety of households and the battle against COVID-19. Likewise, the Police Service in South Africa had received 2320 complaints of gender-based violence in the first week of the national lockdown, 37% higher than the weekly average of 87,290 gender-based violence cases reported in 2019 (Newham & Du Plessis, 2020). Eisner and Nivette (2020) posit that criminological theory indicate that lockdown measures could trigger off causes for an increase and reduction in crime rates and anti-social behaviours, especially property and violent crime.

Under the changing set of the Zimbabwe's COVID-19 control measures, alcohol outlets, bottle stores, bars and other on-site alcohol retailers were closed, which only left supermarkets open for alcohol purchase. This was informed by the fact that these places for alcohol sales are potential breeding grounds and super-spreaders of the coronavirus (Newham & Du Plessis, 2020), and the use of alcohol undermines COVID-19 control and preventive measures such as social distancing and proper wearing of face masks. While the aim of the public protection and health agencies was to ensure that people are safe through complying with the laws, alcohol can lead to non-compliance (Newham & Du Plessis, 2020). According to Maulani et al. (2020), during the first 4 months of lockdown, the ZRP officers arrested at least 100,000 people and charged them for violating COVID-19 control rules. Crimes are 'infectious', but rather than being transmitted by bacteria or virus, they are

transmitted through unruly behaviour (Crawford, 2007) which can be fuelled by substance abuse. In South Africa, for instance, temporary alcohol sales prohibitions were instituted which led to significant reductions in crimes, accidents and other alcohol-related hospitalisations (Newham & Du Plessis, 2020). This can reduce the burden and pressure on the country's law enforcers and emergency services so as to maintain public order while simultaneously protecting people from COVID-19. The reduced strains on the public safety and health-care systems are mainly important during the time when they are at capacity as a result of the COVID-19 pandemic.

Nevertheless, reported crimes such as burglary, robbery and theft declined significantly, with a more than 50% decrease in many countries (Mackworth-Young et al., 2021). The decrease was higher in countries with stricter lockdown measures, and Zimbabwe is one of such countries. It is more likely that the decline was not only due to a decrease in the number of crimes committed but also in the reporting of crimes (World Bank, 2020) and mass public communication. These tend to dispense tangible reminds of the vulnerabilities and anxieties of people amid the COVID-19. As such, it gives immediacy and credibility to the threats from which fears over public safety are deemed to emanate and intensify. Unlike in Zimbabwe, in the Netherlands and New York City, crime dropped by 17% between 16 and 22 March 2020, although vehicle theft increased by 52% in New York City (Newham & Du Plessis, 2020). While the ZRP cannot be ubiquitous across the entire Zimbabwe during COVID-19 time, crime surveillance and mapping during the public health crisis is important as it uses a number of techniques developed to study patterns of diseases. Further, when researchers and scientists map incidents of safety violations, they often discover that spatial clusters of crimes match spatial clusters of diseases (Schweig, 2014). The Centres for Disease Prevention and Control established the Violence Epidemiology Branch, which (now the Division of Violence Prevention) observed that lack of public safety has a significant risk to health.

3.5.7 Outdoor Activities, Crime and COVID-19

Due to the COVID-19 prevention regulations which regulate, restrict and, if considered necessary, ban gatherings at places of amusement, recreation and public entertainment, public safety during the COVID-19 pandemic at the leisure, outdoor and other public spaces has deteriorated. Nkala (2020) observed this especially in high-density neighbourhoods of the cities such as Harare, Bulawayo and Mutare. As observed by Schweig (2014), the most deterrent to human crimes and violence is not a neighbourhood saturated with police officers; it is a neighbourhood active with residents. The idea is that a healthy community or settlement would be, certainly, a safe community. The ZRP's department of fitness training and enhancement sections are part and parcel of an innovative initiative targeted at measuring whether improvements of community health can contribute to promoting public safety in most unsafe neighbourhoods of cities and towns. It emerged that the ZRP has not implemented health-related initiatives in public spaces that have been under-used

by residents and overtaken by crime perpetrators during the COVID-19 pandemic (Ntali, 2021). The rationale is that as people increase outdoor physical activities such as sporting, cycling, dancing and power walking, they could increase their presence in public spaces, enhance their health as well as regain ownership and control of their communities. However, this has become difficulty due to the pressing need for social distancing mostly during the early stages of the pandemic.

3.5.8 Citizens' Safety and Health as Fundamental Human Rights

The current Constitution of Zimbabwe assures every citizen an array of fundamental human rights as part of the bill of rights (GoZ, 2013). The same supreme law lays the base for the institutional, policy and legal frameworks that reinforce the progressive realisation of such rights. The rights include the right to health care, the right to food and water, the right to work, the right to sanitation and housing and the right to education (GoZ, 2013). Some of the COVID-19 control and prevention measures introduced in Zimbabwe to tackle COVID-19 have had implications on these human rights, a threat on safety and health of the public.

While the responses to curb COVID-19 were essential for ensuring health and safety of the public entangled complexity where some human rights were affected. The rights that were impinged on include, inter alia, the right to employment (Section 65), the right to freedom of movement (Section 66) and environmental rights (Section 73) (GoZ, 2013) and the right to education. However, scholars, Snowden (2019), and Fott (2014) argue that as the legal principle s*alus populi suprema lex esto* ('the health (or welfare, good, salvation, felicity) of the people is the supreme law'; or 'Let the welfare of the people be the highest law', public health must be the highest and supreme law, and then everything else follows from it. The interesting case in point for this principle in Zimbabwe is the case of *Stringer v Minister of Health and Child Care & Sakunda Holdings* case number HH 259–20 delivered on 1 April 2020 (see http://zimlii.org/zw/legislation/si/2020/99). The court stated as follows:

> even if there was a threat to the environmental rights of the applicant as an individual, this is a case for application of the principle Salus Populi Suprema Lex…which is the foundation of the Constitution of Zimbabwe…and should apply in cases of extreme emergency when the welfare of the people has to be protected and a trade-off has to take place between the safety of the people and the rights of an individual…

The conclusion drawn from this case is that human rights must be comprehensively understood and protected in a manner that does not expose the safety of the public. The current Zimbabwe's Constitution states that in an appropriate case, human rights and freedoms may be restricted where public safety, public health and public interest are so in demand. What is crucial is that the human action taken to save the public health, interest and welfare must be right. All actions taken must be more

reasonably imperative to safeguard the welfare of the general public from the danger that is threatening it.

As opined by Mohan (2003: 162), a forceful claim for establishing a right to safety emerges in a society where mass population feel the need for a norm on which to base an actionable demand for protection from social, physical or emotional damage. The 6th World Conference on Injury Prevention and Control held in Montreal, Canada, finalised a draft charter on the people's right to safety. Moreover, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights (UDHR) in 1948 with Article 3 of the same Declaration asserting that everyone has the right to security, liberty and life. The UDHR also asserted the rights to live in good health. By adopting these charters, conventions and declarations, citizens are able to claim a safer environment in which to live, safer living conditions, safer products and safer working conditions. The emerging issue of human rights with its particular focus on public safety and health provides a fitting opportunity to bring together experts from these fields with diverse perspectives and sentiments on the value of recognising the emerging issues.

3.5.9 Community Policing Amid COVID-19: In Need of Partnerships?

The COVID-19 pandemic has contributed to uncertain and unprecedented challenges for community policing. This was more challenging in the high-density neighbourhoods of Zimbabwe wherein overcrowding (Mackworth-Young et al., 2021) and a number of COVID-19 control orders were breached. As argued by Laufs and Waseem (2020), emergency situations such as pandemics can have a lasting impact on public trust in the police and police-community relations (Jones et al., 2020). While police response to emergency events and disasters such as COVID-19 can promote public safety and well-being and remove people from harm's paths, weak police response can ruin public confidence and trust in the police forces (Laufs & Waseem, 2020).

The Zimbabwe police forces, local authorities and public safety agencies have partnered with health agencies to respond to the coronavirus pandemic and successes when using public health strategies to solve community problems. However, they need multi-stakeholder partnerships to hone their approaches and bring improved outcomes in terms of safeguarding public safety and health. It emerged from the study that individual community dwellers have lacked the capacity to decipher whether the strategies they use are completely effective towards taming the COVID-19 challenges. As argued by Schweig (2014), community policing is key among the methods to make huge strides into the public safety mainstream. This can ensure that communities are safer and healthier at the same time. In the United States, for instance, public health and safety agencies adopted strategies centred around community engagement and collaboration to solve safety-related community problems (Richards et al., 2006). Policing's capacity to successfully respond to

any public emergency, be it public health or other public crises, is strongly linked to the police agency's will and ability to partner with multi-stakeholders and its planning as well as preparedness (Laufs & Waseem, 2020).

3.5.10 Towards Public Safety-Health Behavioural Approaches

Safety and health systems' performance is critical for tackling and measuring public health crisis and other social ills that come with it. Al-Bsheish et al. (2021) put forward the idea of main safety behaviours which are centred on social distancing, wearing a face mask and hygiene to be practised by the public during COVID-19 pandemic. However, as was the case in Zimbabwe, without public safety performance and compliance, the pandemic will not be manageable. Public safety participation and public safety compliance are key related but distinct parameters for measuring safety outcomes (Yang et al., 2021; Clarke, 2012) in a pandemic environment. Examples of the outcomes include lockdown-related safety breaches, deaths, accidents and human injuries. Safety compliance entails the core activities that individuals and the public need to do so as to maintain safety in their places (Yang et al., 2021), for example, correct wearing of PPE and hygiene practices. Evidence from Zimbabwe reveals that there have been a reported number of non-compliance cases (Mackworth-Young et al., 2021) in maintaining social distances, avoiding social gatherings and respecting curfew times. The ongoing COVID-19 in Zimbabwe is a typical biological hazard that has impacted on public safety outcomes due to some cases of non-compliance. Nonetheless, public safety using PPE and through observing risk reduction tended to be adversely correlated with neighbourhood crimes. Thus, public safety compliance behavioural approach among mass population is beneficial in providing public safety, from individuals and households to work. Participation in safety matters entails individuals' voluntary behaviours that could develop a safety-supportive environment rather than directly guaranteeing individual safety (Neal, Griffin, & Hart, 2000). Of course, public safety is a fundamental responsibility of the state, and participation of Zimbabwean people could ultimately enhance responses to the COVID-19. The Civil Protection National Policy requires every citizen of Zimbabwe to assist where possible to limit or avert the adverse effects of disasters (Ministry of Local Government, 2009). With close to 17 million Zimbabwean population, public safety and health agencies will not cope with countrywide safety non-compliance; thus, participation is critical.

3.5.11 Entwining Public Health and Public Safety

As evidenced from the study, public health and law enforcement entities have just begun to realise the effectiveness of public safety and health partnerships towards containing the pandemic at the same time maintaining public safety. In order to

further promote such joint actions, endowment needs to bring together public health experts, police chiefs, policy-makers and researchers from across Zimbabwe for constructive round-table discussions to chart the way forward. They need to agree that, due to poor economy of the country, as budgets are tightening across ministries and sectors, the traditional ways of ensuring public safety and fighting crime are changing more particularly with the coming of the COVID-19 pandemic. This can identify opportunities for collaborations between law enforcement and public health officials. Subsequently, funding for crime prevention programmes involving joint initiatives between the two areas that are critical during and after the coronavirus pandemic.

3.6 Conclusions and Recommendations

The chapter has sought to explore and examine the nexus of the public health-safety amid the COVID-19 pandemic which can help in mapping the way towards improving safety and health institutions in Zimbabwe and other countries in the Global South. It was noted that the ability of health and safety care services to keep up medical and non-medical services during the COVID-19 pandemic was affected by lack of coordination, staff members' infections as well as resource determinants. The primary responsibility of public safety and health institutions is their authoritative exertion of power to deliver safety services to the citizens so as to protect them from the disruptive impacts of biological and/or natural hazards such as COVID-19. The chapter concluded that the health and safety systems have left public safety and public health systems very 'loose' to contain the coronavirus pandemic and its associated impacts. The pandemic has reminded people in developing countries and perhaps developed nations that they live in the unsafe, insecure and disorderly times in the history of humanity. The dangers threatening human lives have increased as their safety has become precarious. In this age where people feel more traumatised, insecure, threatened and frightened, public policy responses and governance have to be more inclined to security and safety of the people. Accurate reporting and communication concerning public safety-health will improve understanding of the safety and health risks, enhancing the capacity to offer right policy prescriptions to relevant institutions. This promotes the provision of suitable post-pandemic or disaster assessment. Safe and healthy communities are fundamental for public health disaster responses and are the cornerstone upon which policy guidance for the re-opening of the economy must be based. The effective health approaches and management of COVID-19 will be largely measured on the ability to maintain public safety. Basically, understanding the nexus of public safety and health institutions during a health emergency is thus a fundamental requirement for impelling the entire public health responses and preparedness. A number of interventions executed in curtailing the COVID-19 and other possible future pandemics should be considered if they are actionable and viable recommendations for public safety and health agencies operating during a pandemic. Results from the chapter establish the

foundation in which modern-day governance of public protection should be rethinked with obsessive quest on the part of multi-agency for safety, security and order. This enables the government to inform and infuse diverse overtones of public health emergency aspects to everyday life of people.

Based on the findings and discussions, the chapter proffers the following recommendations: the future public safety systems should be resilient and interoperable responding to public health crisis, supporting the health services and responses of the Ministry of Health and other public health entities. Thus, the development of advanced safety and health surveillance technologies for public health-safety emergency networks as support of Zimbabwe's public health-safety systems in confrontation of the deadliest health crises. The COVID-19 pandemic prompts defensive actions and suspire life into institutional quests for public safety and security. Scientific and empirical research needs to profile the experiences of the public safety agencies providing essential services to the community. The government of Zimbabwe also needs to initiate safer community programmes which can take the nations' public safety approaches out of the tapered confines and ways of formal public policing and include a wider stratum of societal control methods, formal and informal, operating at the local level. Coordination with non-state actors is also crucial. Public safety behaviours need to be linked to the laws and control regulations to facilitate compliance by the public. The ZRP needs to embrace digital policing and also cloud-based technologies for decentralised operations to position public safety agencies to be better prepared for the events of the future.

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