Chapter 4
Devolution as a Health Governance Paradigm Amidst the COVID-19 Pandemic in Zimbabwe: Convergences and Divergences

Kelvin Zhanda and Leonard Chitongo

Abstract The emergence of COVID-19 has re-affirmed the importance of devolved governance models for enhancing health systems in curtailing pandemics of this nature. The exercise of devolution in Zimbabwe is embedded in the constitution. In addition, the state has a legally enshrined role to play in safeguarding public health. Fulfilling such a role requires the state to govern in a manner which respects all citizens and ensures an equitable distribution of resources and services across the country. The objective of this chapter is to examine the opportunities and constraints associated with devolution as a governance model by investigating its efficacy in curbing the spread and devastating effects of COVID-19 in Zimbabwe. The research methodology involved an extensive literature review of published documents, press releases and reports aided by content analysis. The findings presented in the chapter show that devolved governance is vital in ensuring that prevention measures against COVID-19 are befitting to the local context as it enhances efficiency, accountability and coverage in the delivery of COVID-19 response services. Operations of local-level health front-line institutions in Zimbabwe have been impacted by the lack of decision space and high bureaucracy as the levels of decision-making are not closer to the local communities. If devolution were fully in place, COVID-19 containment measures would have been easy to implement, thereby enhancing the control of the spread of the virus and minimising its health and socio-economic impacts in Zimbabwe. Therefore, the chapter recommends the devolution of power and responsibilities to sub-national tiers of government, the equitable allocation of national

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resources and the participation of local communities in the determination of and responses to public health emergencies within their areas. In conclusion, devolution of decision-making powers from national government to local governments is one of the pre-conditions towards shaping an inclusive public health policy and building health-resilient communities.

Keywords COVID-19 · Devolution · Health governance · Zimbabwe

4.1 Introduction

As reported internationally, a virus which falls in the family of the betacoronavirus 2 (COVID-19) was detected in Wuhan, China, in December 2019 (World Health Organization 2020). China announced the lockdown of Hubei Province on 23 January 2020 as a response to the COVID-19 pandemic (Gumbu et al., 2020). Since then, COVID-19 has spread across the entire globe such that by 27 December 2021, 278 million cumulative cases and 5.4 million human deaths had been reported (World Health Organization 2020). In the Global South, Africa in particular, the number of confirmed COVID-19 cases as of 17 June 2020 were at 270,660 with 72,490 deaths. The highest number of COVID-19 cumulative cases (n = 80,412; 29.7%) and deaths (n = 1674; 23.1%) were recorded in South Africa (Madhi et al., 2020; Government of South Africa, 2020) followed by Morocco with 524,475 (Galal, 2021). In Zimbabwe, the first case of COVID-19 was recorded on 21 March 2020 (Zhanda, 2020), and by 13 April 2020, the country had recorded 14 cases and 3 COVID-19-related deaths (Murewanhema & Makurumidze, 2020). The COVID-19 pandemic has had intense impact on the lives of all Zimbabweans, affecting all corners of society and the economy.

A wide array of measures to curb transmission of COVID-19, enable health services to cope with cumulative cases and deaths and support the economy have been put in place across Zimbabwe. Like many countries across the globe, Zimbabwe instituted lockdown measures and social distancing restrictions to curtail the spread of the virus. Although the virus is deadly on itself, these responsive measures have wreaked profound havoc on people's livelihoods, and regrettably people lost their lives (Murewanhema & Makurumidze, 2020).

As countries reacted to the COVID-19 pandemic, some have centralised decision-making, whereas others, such as India (Kosec & Mogues, 2020a), Germany and the United States, have left key policy response choices to state sub-national governments, or even municipalities (Kosec & Mogues, 2020b), giving a green light for individualised and localised measures. While scholarly attention has largely focused on global and national COVID-19 policy responses, these endeavours will eventually need to be undertaken by sub-national institutions. In this regard, it is the nature and character of local governments, and their relationship with a broader set of devolved governance configurations across scales, which is likely to play a pivotal role in determining the outcomes of different interventions, with significant

implications for the trajectory of COVID-19 infection. However, this approach is viable only if the sub-national governments receive sufficient support and there is strong coordination across all tiers of government (OECD, 2020). While China, for instance, finally had positive results in battling COVID-19, its decentralised administrative system initially contributed to gradual response by the Wuhan local government which brought about fatal outcome for all countries across the globe (Dutta & Fischer, 2021). The Indian government, after initially responded with a centrally directed COVID-19 pandemic response, has turned to a devolved strategy, with the merits of such approach witnessed (Kosec & Mogues, 2020b). Moreover, these same approaches affected productive and social services that were important to peoples' lives in Ethiopia, in 2000 (Kosec & Mogues, 2020b). Such varied experiences and perspectives have framed a discussion concerning the (de)merits of a devolved governance and decentralised service delivery in pandemic response (see OECD, 2020), especially in low-income countries which are vulnerable to COVID-19 impacts due to weak health systems. Devolution is thus an important theme to explore in understanding contemporary public health governance. In the United Kingdom, for example, the devolutionary process which was introduced in 1999 (Tomaney, 2016) has stirred debates over the control and management of COVID-19 with the UK and Scottish governments responded with varying degrees of success (Morphet & Clifford, 2014).

Devolution theoretical arguments and rationale speak to why local-level government entities perform well on quite a number of grassroots national government functions including public health responses. In this chapter, we advance three principal reasons for devolved governance's efficacy in health governance, particularly in COVID-19 response. Firstly, due to devolution of government, local governments are likely to be more responsible and responsive to the peoples' urgent necessities as they are embedded in (or closer to) the communities that they serve (Dutta & Fischer, 2021). Besides being more accessible to the general public as compared to centralised governments, devolved governments are integrated in a motivator structure that can make them more accountable to local needs (Morphet & Clifford, 2014). This could be a result of legal obligations, unspecific threat of public legal opinion and vitiated individual reputation (Dutta & Fischer, 2021). Secondly, devolution connects sub-national governments closely to the people and hence is able to steer context-specific grassroots conditions (ZILGA, 2021). On the contrary, in centralised states, local governments are often far more knowledgeable about grassroots needs, able to garner key local players, correctly positioned to assess activities at the local level and able to evaluate and address context-specific problems that arise. Lastly, devolution of government powers and responsibilities legitimises local government more than external stakeholders for conducting various kinds of governmental regulatory or restricted functions. In most countries in the Global South like Zimbabwe, South Africa and Uganda, local government officials are directly elected by the public. The public's capability to engage with their local government leaders may similarly add the legitimacy of their actions. According to Longstaff and Yang (2008), trust in devolved governance can be an important factor in effective communication management in times of disasters. Quinn et al. (2013) observed

that distrust in government entities often obstructs concerted effort and cooperation with public health orders particularly in crisis times, as seen during the H1N1 pandemic in 2009. These tenets of devolved governance are more likely to be crucial for the ongoing COVID-19 pandemic.

This chapter proffers an exploratory analysis of how sub-national tiers of governments are being operationalised for COVID-19 pandemic prevention and control in Africa with specific focus on Zimbabwe. As the COVID-19 continues to ravage the country, it is of paramount importance to examine how well the central, provincial, metropolitan and local tiers of the state deliver critical health services that avert health and socio-economic disasters and lead citizens to wellbeing. Critical infrastructure and essential services such as clean drinking water, sanitation and hygiene (WASH), housing, food systems and other critical health infrastructure to supporting vulnerable grassroots populations during and after the pandemic. Evidence from the study shows that despite having over 92 elected sub-national governments and with critical aspects of a devolved governance system in place (ZILGA, 2021: 13), Zimbabwe has arguably failed to thoroughly undertake distensible mobilisation of local governments to contain the pandemic. A critical question that develops is why Zimbabwe faces challenges in its countrywide COVID-19 responses emanating largely from marred intergovernmental relations despite having (since colonial era) a comparatively devolved governance system. Zimbabwe's lack of democratic and 'transparent' institutions could leave important health and economic services neglected as local societies respond to the pandemic. The desirability and significance of devolution as a key form of decentralisation (Rondinelli & Cheema, 1983) lies in the appropriation of authority to institutional levels that are best placed to deal with specific issues. As such, the COVID-19 pandemic has pointed out to the need for institutions that are better-placed to deal with the deadly virus. Additionally, the centralisation of the country has left the fight of COVID-19 more strenuous than it should be. Apparently, Zimbabwe is a 'centralised' jurisdiction or state, hence the need for devolution. While the pandemic, in some ways, has been a 'unifying' force, as the entire country's institutions became seized with responding to this huge existential health hazard through coordination and collaboration, the centralisation of the country's governance has left the fight of COVID-19 more strenuous than it should be. Moreover, despite the devolution agenda being a central tenet of local governance since Zimbabwe's Constitutional Amendment (No. 20) Act of 2013, it would not be practically implemented until 2018 when the Second Republic Government of Zimbabwe rose into power (Chigiya-Mujeni, 2021). Unfortunately, the outbreak of the COVID-19 has somehow derailed the take-off of devolution in Zimbabwe.

The economic, social and health crisis of COVID-19 in Zimbabwe has been an additional extension of tension and pressure on the calls over devolution issues already strongly advanced. In this chapter, we focus on devolution in Zimbabwe and its ramifications for the curtailment of the coronavirus in the country. Our focus in Zimbabwe was informed by the fact that the devolution agenda is currently at its heights and pressure mounting within political and scholarly discourses. Since the inception of its heated constitutional debate, which could have across-the-board

penalties for its governance in Zimbabwe, there have been little if not tangible outcomes regarding its implementation. Arguments posed in the chapter engage with whether such debates on devolution have spawned lessons that policy-makers, stakeholders, scholars and general public can draw upon to cement the role that substate tiers can play towards development of Zimbabwe, particularly in the case of battling with the health challenges – COVID-19. Therefore, the COVID-19 pandemic has presented an opportunity to examine the health dimensional benefit possibility of devolution, especially if it were fully in place when the pandemic strikes Zimbabwe in 2020. Health emergency responses, planning and preparedness, should be closely interwoven with notions about localism and regionalism, inorder to make interventions resilient and sustainable. The weaknesses of local governments (rural and urban councils) in responding to COVID-19 (with variable degrees) is embedded not only in the legislation but also in political and socio-economic capacity shown in Zimbabwe's governance philosophy restraining the sub-national government's response capacity and potential (Mutenga, 2021). We proffer arguments that a raft of lockdown measures, based on devolution in facilitating COVID-19 testing, data, demographics and apt measures for countrywide economic sustenance, including, inter alia, social safety net support and a greater emphasis on human health and livelihood resilience, can save lives, as well as limit financial costs and ease long-term impact of the pandemic.

We particularly examine the relationships between public health governance and devolved functions of local authorities in the Zimbabwean government since March 2020. This is mainly important in the context of Zimbabwe where a gap exists in which discussions about devolution have not been focused towards public health governance. However, there have been no discussions of devolved health planning systems and their resultant effects in each region or province of the country. While we proffer the discussions around the execution of policy divergences within developing countries such as Zimbabwe following devolution, we revolve on the relationships between the intergovernmental- and local-level health-related institutions and entities that hold policy vital functions in a 'model' devolved Zimbabwe governance. While the current body of scholarly literature has noted the implication of devolution, there has been no contemplation on the connections between these entities and the centre-local model of a devolved country.

4.1.1 Devolution in Theory

The theoretical foundations of devolutionary ideals are traceable as far back as 507 B.C. to the classical contributions of Cleisthenes, a leader in Athens who introduced a system of governmental reforms dubbed '*demokratia*', meaning 'rule by the masses or people' (Tomaney, 2016). This saw the birth of democracy, paving way for the establishment of mountain-side courts open to the citizens, led by lottery-selected jurors. These developments allowed Athenians to make decisions which directly affected their communities. Tomaney (2016) echoes that devolution

on groups of powers and privileges, associated with the performance of public service, is an ancient governmental practice.

The concept of devolution is defined and conceptualised in multiple varying ways with its meanings (Jacobs & Chavunduka, 2003) and nomenclatures evolving over time. Nonetheless, what matters most is to frame and address the following questions around the concept of devolution: what is devolution? What does it mean in practice? And why do countries or states have or must have devolution? Different scholarly perspectives view the concept of devolution through a collection of diverse and overtly inconsistent analytic lenses. Such divergence is widened by differences between scholars researching about devolution as it applies to the general public governance and administration field, in contrast to the scholars that seek to apply devolutionary tenets specifically to the health sector. Still, critical questions abound when one seeks to appraise the actual results and efficacy of devolution on urgent policy issues within health systems especially its impact on the capacity to render long-term responses and resilience to pandemics or to build coordinated healthcare networks. As such, it clearly appears that devolution can cover a number of possible evaluations, with what appears to be positive outcomes in certain contexts or to some scholars becoming negative in other contexts or to other scholars.

Although typically defined in the fields of policy-making, public management and planning, as the process where central government transfers executive, legislative, administrative as well as financial decision-making powers to sub-national governments that have legally recognised jurisdictions within which they deliver public services to areas to whom they are accountable (Bankauskaite & Saltman, 2007), it has different characteristics for different scholars. Scholars such as Bankauskaite and Saltman (2007) argue that the concept of devolution is closely linked to decentralisation and the two concepts are often interchangeably used although they are distinct in practice. Devolution is the handover of authority to autonomous local-level tiers of executive government, such as district and provincial councils, which are lawfully established as separate entities of governance. On the other hand, Sherwood (1969) does not consider devolution to be a legitimate form of decentralisation. Sherwood (1969) argues that devolution is a concept quite separate from decentralisation, in that it entails the divestment of functions by the central government and the creation of tiers of government not in the direct control of the executive government. He opines that devolution typify a concept of separateness in public governance. Sherwood (1969) goes on to argue that decentralisation and devolution are different phenomena as 'decentralisation' denotes an intra-organisational structure of relational power, while devolution denotes an inter-organisational structure. By and large, devolution is the transfer of governmental powers, responsibilities, resources, accountabilities and authority from national to sub-national tiers of government (ZILGA, 2021). Devolution exists in a unitary state wherein administrative and political power is 'equally' distributed between a national government and local spheres of the government, for instance, local authorities, metropolitan and provinces.

These various conceptions of devolution can be simply interwoven to mean the multi-stakeholder instrument on and process for transferring authority from central

government to the sub-national tiers of government with the aim of promoting sustainable democratic governance. Moreover, devolution fosters equitable distribution of resources and participation of communities in decision-making concerning issues affecting them. The aim of devolution is to promote and ensure state accountability and delivery to the public. Therefore, governance policy thrust needs to push devolution that enhances effectiveness and efficiency of operations of local government institutions, by minimising bureaucracy through lowering of policy-making closer to the citizens (ZILGA, 2021). It is also viewed as important to improving accountability and legitimacy of state (political) institutions, enhancing the efficiency of public services, fostering the growth of regional and local economies as well as incubating innovation of policies (Moyo & Ncube, 2014; Tomaney, 2016). In Kenya and Zimbabwe, for example, devolution has been an inherent part of the constitutional reform, with the aims of establishing a more inclusive governance system, redistributing central government's power and sharing resources more equitably.

4.1.2 Devolved Governance in Zimbabwe: Brief Overview

This section is important for understanding devolved governance structures in Zimbabwe, which is critical for harnessing countrywide health systems towards battling COVID-19 and other diseases of the same nature. Despite being a contentious topic in Zimbabwe, devolution is vastly researched in Zimbabwe (see Chikwawawa, 2019; Mapuva, 2015; Muchadenyika, 2015; Nhede, 2013; Chirisa et al., 2013; Chigwenya, 2010), focusing much on its implications on constitutionalism, democracy and accountability rather than service delivery particularly health services. Understanding the contemporary context of devolution in Zimbabwe requires a concise narrative on the trajectory and implementation of devolution built upon Zimbabwe's administrative decentralisation which started as early as 1883. However, detailed account of this background is beyond the purview of this chapter. In 1980, Zimbabwe inherited a three-way and dichotomous local government system comprised of urban councils, 'white' rural councils and 'black' rural local authorities fragmented along racial lines (Masundu-Nyamayaro, 2008). Nevertheless, in 1984 and 1985, the government laid out the new local government structures. This saw the introduction and establishment of village, ward, district, provincial and national development committees so as to promote bottom-up development planning in which development issues were identified and crafted at village level, directed through the ward, district and provincial levels to the national level (Chigwata et al., 2017). The rationale was that the national (central) development plan should contain the priority views of this at the village and ward level. By the year 2000, it turned out clearly that decentralisation had failed to yield projected outcomes as the central government lacked commitment to it and spirit of making local government a separate sphere (Gasper, 1991). In emphasising the absence of devolution in Zimbabwe, Chigwenya (2010) denoted that 'decentralisation without devolution' in the country will have limited impact on development.

The promulgation of Zimbabwe's new constitution (Amendment (No. 20) Act of 2013) in May 2013 ushered in devolution as the uttermost form of decentralisation in Zimbabwe. Such constitutional response was compelled by protracted grievances concerning regional imbalances in development and service delivery outcomes as well as the centralisation of the central government powers and public sector resources. Since then, devolution has been a central tenet of local governance, though it would not be practically implemented until the Second Republic that rose into power in 2018 (Chigiya-Mujeni, 2021; ActionAid, 2014). The Zimbabwean government is currently pushing the devolution agenda as it considers it as a pillar to attaining upper middle economy status by 2030 (Zimbabwe Economic Policy Analysis and Research Unit (ZEPARU) 2020: 1). The framework and parameters for devolution are enshrined in Section 264 of the Constitution of Zimbabwe Amendment (No. 20) Act of 2013 (Chikwawawa, 2019) and Devolution and Decentralisation Policy (GoZ, 2020). This is supported by other subsidiary legal pieces such as the Rural Councils Act (Chapter 29: 13), Urban Councils Act (Chapter 29: 15), Rural Councils and Administration Act (Chapter 29: 11) and Regional, Town and Country Planning Act (Chapter 29: 12), which need review and amendments to align with the country's Constitution. The process to amend the Provincial Councils and Administrative Act (Chapter 29: 11) to align with the Constitution is underway.

To facilitate devolution, Section 5 of the Constitution of Zimbabwe organises the government at three levels mandated by Section 264(1) of the Constitution to implement the devolution agenda. These are national government, provincial and metropolitan councils and local authorities (see Fig. 4.1). The powers exercised by these sub-national tiers of government are derived from a number of Acts of Parliament which include, among others, the Rural District Councils Act [Chapter 29: 13]; the Urban Councils Act [Chapter 29: 25]; the Regional, Town and Country Planning Act [Chapter 29: 12]; the Environmental Management Act; the Water Act; the Public Health Act; the Shop Licensing Act; and the Roads Act. The national tier of

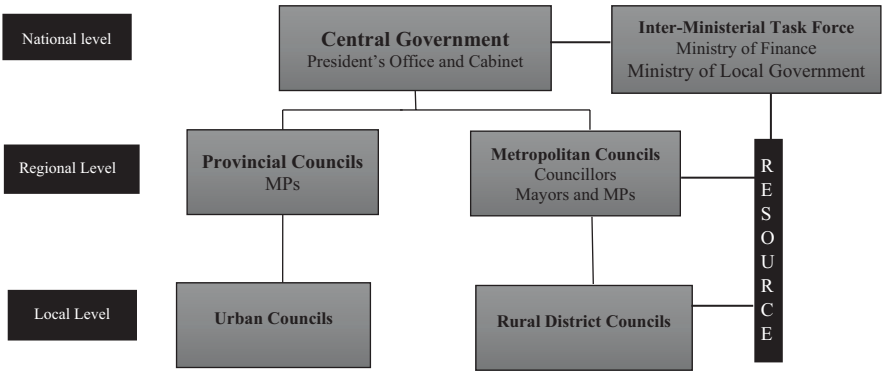

Fig. 4.1 Zimbabwe's three-tiered system of governmental structure. (Source: Authors)

government is the executive arm of government which is composed of ministers appointed by the president in accordance with the Constitution (ZEPARU, 2020). As a unitary state, Zimbabwe is governed by one executive arm of the government. The central government is followed by the second tier of government (provincial and metropolitan councils) of elected and proportional representation public representatives elected using constitutional provisions contained in Chapter 14 (2: 268) (for provincial councils) and Chapter 14 (2: 269) (for metropolitan councils). Lastly, the third tier is the local government level which includes urban councils (UCs) and rural district councils (RDCs) (Webinar IV, VI, 2020; Chigwata & de Visser, 2018). The country has 92 democratically elected councils that in the main prepare and approve their budgets and raise resources locally to finance their activities.

The distribution and mobilisation of resources, policy-making decisions, political power and administrative responsibilities and governance are meant to be devolved through the stated tiers of government (Muchadenyika, 2015). The provincial and metropolitan councils have important functions which consist of planning and implementation of economic and social development activities; coordination and implementation of government programmes; promoting tourism and developing facilities for the same purpose; planning and implementation of measures for the conservation and management of natural resources; and monitoring and evaluation of the use of resources (GoZ, 2020). However, ZILGA (2021) raised concerns regarding the political and technical powers bestowed upon the provincial and metropolitan councils. On the other hand, the RDCs and UCs have a range of powers and responsibilities as assigned by their respective Acts of Parliament. These include welfare services and basic municipal services which include, inter alia, public health; provision of housing (including serviced residential plots) and public utilities (such as electricity); education; water, sanitation and sewerage management; and waste management. These functions are critical infrastructure during the period of a pandemic like COVID-19. In the same way, for a country to be considered ‘developed’, the health of its citizens has to be safeguarded.

Scholars Muchadenyika (2015) and Chikwawawa (2019) argue that devolution enshrined in Zimbabwe’s 2013 Constitution is not yet implemented because the ‘old’ governmental structures still dominate and stakeholders have revealed the troubles of implementing devolution without subsidiary statutes to implement the provisions of the Constitution. In contrast, ZILGA (2021) and GoZ (2020) have a different perspective as they report that Zimbabwe has most of the critical aspects of a devolved system in place and has undergone some of the reforms necessary for effective implementation of devolution. The Zimbabwe Local Government Association (ZILGA) (2021) has uncovered that national government is unwilling and unable to implement devolution fully. Experiences of local government practitioners reveal scepticism, frustration and mistrust pertaining central government’s devolution endeavour. Presently, the design of devolution and its implementation are not spearheaded by an intergovernmental platform, and thus, it is weak and slow on local government’s voices (ZILGA, 2021; Chikwawawa, 2019).

4.1.3 *Zimbabwe's Devolved Emergency and Disaster Risk Governance*

The Zimbabwe disaster management portfolio is relatively devolved from the national and the sub-national tier of the government in order to facilitate local communities' participation in decision-making concerning their challenges. The emergency management system in the country is spearheaded by civil protection entities at the national, provincial and district levels in accordance with civil protection legislative arrangements (GoZ, 1989). The hierarchical structure (see Fig. 4.2) starts from the Office of the President which means that national disasters are handled at the highest level from the top to bottom and bottom-up approach which then enhances coordination across all institutions involved. Since the Civil Protection Act sets the functional and legal relationships among the relevant institutions, a coordinated approach is manifest in a way that all the relevant government departments, local authorities' parastatals, non-governmental organisations (NGOs) and private sector can have a niche in disaster risk management process (Ministry of Local Government, 2009). The national civil protection includes key ministries including the Home Affairs, Ministry of Information and Ministry of Finance for the allocation of funds.

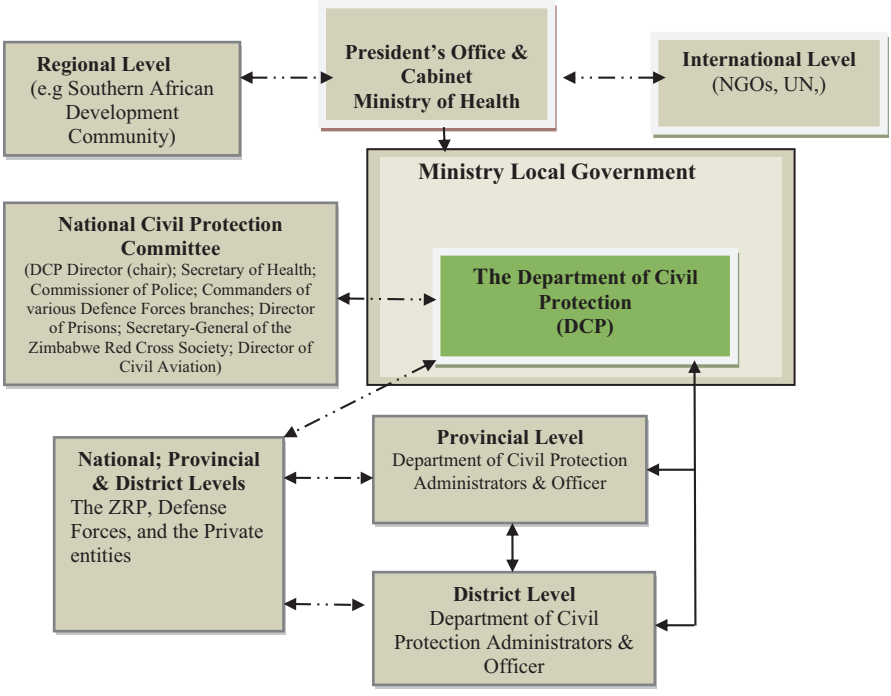

Fig. 4.2 Devolved structure of the disaster management system in Zimbabwe. (Source: GoZ (1989))

Besides facilitating coordination, this devolved structure ensures effective emergency responses and preparedness. Ultimately, the national, provincial, district, local authority, non-profit and private sector levels are required to plan for disasters by producing operational plans for emergency preparedness and response, and the plans would be brought into operation in the event of a disaster (GoZ, 1989; 2001). To enhance coordinated efforts, localised plans which would specify the mechanisms and procedures for issuing responsive procedures are expected to merge into the national plan (Ministry of Local Government, 2009).

4.1.3.1 Health System Devolved Governance in Zimbabwe

Zimbabwe's public health system has undergone extensive processes akin to decentralisation and devolution reforms. The country's healthcare system has retained a number of the arrangements since the first quarter of 1980, though lack of funds and recent wearing down of health workers for sustaining health operations have restrained the capacity of the decentralised health structures (Osika et al., 2010). This widened the divide between the function and structure of the decentralised structures as originally prescribed.

An overriding theme of decentralisation dominated the health delivery system of Zimbabwe, with health services provided at four levels: quaternary, primary, secondary and tertiary. Between 1990 and 2000, when the country's health system was not relying on foreign donors' substantial support, the government lured various new players which then managed particular 'areas' of the health system (Osika et al., 2010). Zimbabwe has also an extensive network of private healthcare providers, comprising of faith-based and for-profit healthcare providers. The private healthcare providers have more decision-making discretion and function generally with limited control from the central government except for regulatory obligations (GoZ, 2020) as they are more autonomous. For instance, pharmaceutical management actors became semi-autonomous players in which funds were generated from returns for the services they provided.

The decentralised health governance structure in Zimbabwe embodies elements of devolution. The devolved structures of the public health system are represented by health committees which are present at the provincial, district and rural health clinic levels. At the lowest level of the health system, there are rural health clinics, and their strategic support comes from rural district councils (Osika et al., 2010) and financial and administrative support from the District Health Councils (DHCs). In theory, Provincial Medical Directorates (PMDs) and DHCs administer their functions with input from provincial- and district-level health committees that provide community oversight and supervision. Principally, these committees are autonomous structures made up of local leaders, civil society and community members that were put in place via the Health Services Act. Hospitals and rural health clinics receive strategic input and direction from hospital- or clinic-specific committees as well, while they receive financial and technical support from the PMDs and DHCs (Osika et al., 2010). As such, these health entities receive input from the devolved structures in the Zimbabwean health system.

However, it should be underlined that Zimbabwe's health system has recently reverted towards centralisation. The MoHCC has been gaining more control over policy-making, with the health system increasingly becoming reliant on donor funds, for example, from USAID and the United Nations and European Union, for supporting significant health programmes (Osika et al., 2010). At the national level, the health system of Zimbabwe is defined by a centralised decision-making body, the MoHCC, which is responsible for health policy, regulation, mobilisation and allocation of resources, human resources planning, surveillance, monitoring and evaluation and liaising with NGOs and donors. Additionally, the MoHCC approves of human capital employment at the district and provincial levels and provides administrative guidance on coordinating responses to public health issues. For instance, during the cholera outbreak in 2008, MoHCC coordinated responses. This is consistent with assertions by WHO that ministries of health are responsible for overseeing health development through the enhancement and implementation of principal health system functions, including governance (regulation and policy-making), provision of health services and healthcare financing, and providing inputs for health development such as human resources for biomedical technology and health. This role largely contributes to increasing equity in access to healthcare, particularly in rural and remote areas where qualified private providers, concerned about their income, are in limited supply. While its national MoHCC still retains responsibility for national policy formulation and planning, it devolved some functions to district-level administrative units, such as operation of health centres and village health teams (Osika et al., 2010).

The complex structure illustrated in Fig. 4.3 provides for central government control and local communities' input. The reality in practice, however, has proven to be quite different. Zimbabwe has many health planning structures in policy though they faced a plethora of problems on the ground, subverting their role in health systems, especially in lifting the priorities of low-income communities. These problems were summarised by Stewart et al. (1994): ambiguities in authority and roles; top-down selection of members; constricted powers for generating local revenue; lack of regular elections; lack of direct participation of many traditional and civic leaders; lower levels' deficiency of control of substantive level of resources; dominance of technical over elected personnel; low levels of beneficiary feedback and participation; weak relationship between sectoral budget allocations and district/provincial plans; lack of interest in these structures by health staff who do not see themselves as accountable to these structures; lack of clear feedback to communities; lack of incentives for local committee members; and weak planning capacity. A good number of the PMDs and DHOs are understaffed, and only 35% of district hospitals and 29% of provincial hospitals still have a functioning health committee (Osika et al., 2010). Rural health clinics have fared better; 65% of them still receive support from the RDCs. The weakness of these committees has meant that hospitals and health clinics have received less strategic support from local authorities and communities. As a result, the devolution of strategic oversight to community committees has not worked as well as originally planned.

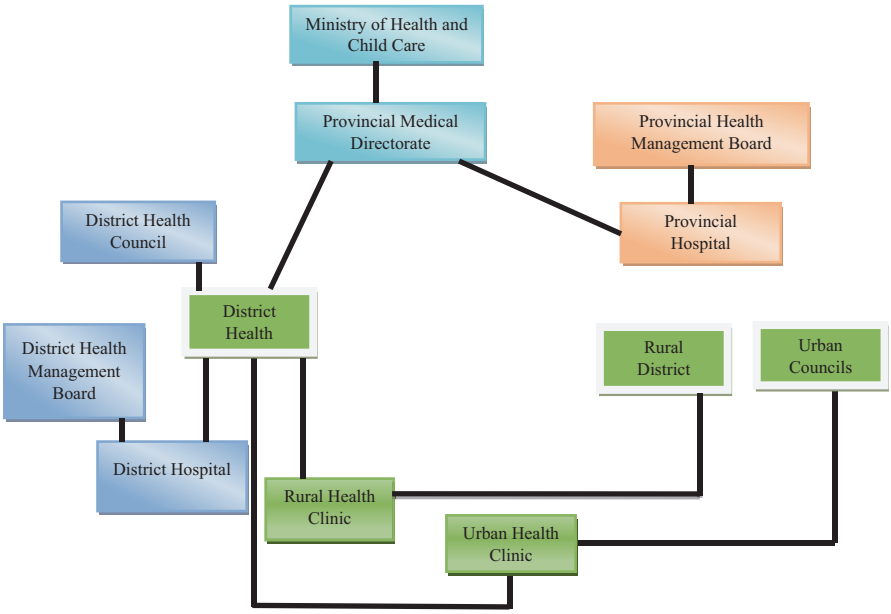

Fig. 4.3 A visual outline of the devolved health system of Zimbabwe. (Source: Authors)

In the devolved system, health governance occurs at national and sub-national levels (McCollum et al., 2018: Kimathi, 2017). As such, devolution in Zimbabwe entails health governance should take place at central, provincial and metropolitan and local levels. The RDCs and UCs have a range of powers and responsibilities which include welfare services and basic municipal services which include public health; provision of housing and public utilities (such as electricity); water, sanitation and sewerage management; waste management; and education. This supports the view by some proponents of devolution that health provision should be one of the core functions of local government in a devolved government system. Section 96(3) of the Urban Councils Act states: 'Every council shall appoint a health and housing committee which shall be responsible for health and housing matters relating to the councils'. On the other hand, Sections 25 of the Second Schedule and 34 of the First Schedule of the Rural District Councils Act oblige council:

> subject to any other law, to provide and operate hospitals, clinics and dispensaries and to take any measures or provide any facilities which are considered necessary for the maintenance of health, including dental health.

These roles are experienced in many countries such as Brazil, where the Unified Health System places the responsibility of health planning primarily at the municipal level, and in such process, which is carried out every 4 years to make resource allocation decisions and establish health regulations and guidelines, results from situation analyses at municipal and state levels are considered (Pan American Health Organization, 2008).

4.2 Research Design and Methodology

The chapter employed a qualitative approach as it permitted the inductive collection of sufficient data through seeking to understand the 'how' and 'why' questions concerning devolution and public health services in specific contexts (Pope & Mays, 1995) in a COVID-19 environment. The study was largely based on extensive review of secondary sources of data and six webinars conducted in Harare, Zimbabwe. The document review sources include academic journals and a multiplicity of Internet sources. Document review is based on secondary data which is not specifically collected for this purpose. This has implications on validity of the results as the data can be over- or under-rated. However, cross-validation was undertaken in which many articles (> 45) were consulted to come to a real conclusion. Secondary data sources were utilised in this chapter because they give a quick and comparatively easy method of acquiring a comprehensive understanding of devolution and health services nexus amidst COVID-19 in Zimbabwe. A desk review approach aids in collecting, organising and synthesising information (Shuttleworth, 2008). We consulted Acts of Parliament and the Government of Zimbabwe's issued guidelines and orders for COVID-19 management in the form of documents. Overall, we reviewed over 25 documents related to COVID-19, consisting of acts, guidelines, directives and orders, as well as newspapers (press) releases. In addition, a number of documents which underpin devolution were consulted including the Devolution and Decentralisation Policy.

We also thoroughly read the Public Health Act and Civil Protection Act, 1989, under whose provisions the lockdown was imposed. During the early days of the lockdown, major notifications and guidelines relating to COVID-19 was primarily being issued by the Ministry of Health and Child Care (MoHCC) (GoZ, 2020). In addition, we scoured the Zimbabwean Government's websites of the Ministry of Health and Child Care, Ministry of Local Government and Ministry of Home Affairs. We particularly focused on sections titled 'coronavirus', 'publications', 'news' and 'resources' to take out relevant data specific to COVID-19, with data on COVID-19 control measures, localised lockdown, essential services and local COVID-19 responses. In addition, we got similar COVID-19 containment and local government-related documents issued by the national government tiers of local authorities with their departments of health, and development, on the respective government online websites.

Newspaper articles that carried stories on devolution, COVID-19 and other related publications were also used. These include national news media like *The Herald*, *Sunday Mail* and *Newsday*. Newspaper articles though not quite reputable for scientific research helped the authors to gather up-to-data information and clarify the COVID-19 situation in Zimbabwe. Furthermore, they help in our understanding of the possible prospects and challenges of interventions and programmes which reduce the nature and severity of the pandemic. Thus enabling a deep introspective into understanding the country's devolution model as a development strategy. This makes it easy to come up with informed recommendations for future policy interventions.

At last, the authors closely followed the proceedings of webinars (n = 6) about the role of national government and local authorities on devolution (Webinar I, 21 September 2020; Webinar II, 21 September 2020; Webinar III, 22 September 2020; Webinar VI, 28 September 2020; Webinar IV, 22 September 2020) co-organised by the Zimbabwe Local Government Association, National CEO's Forum for Rural District Councils and civil society organisations in Zimbabwe. These online discussions helped further complement and corroborate data gathered through desk reviews, thus providing at least some ways to triangulate the findings and contextualise them within broader governance processes occurring across Zimbabwe between March 2020 and December 2021 (the period of our research) amidst the COVID-19 pandemic. Thematic content analysis was used to analyse the data so as to come out with reliable and valid information. Selected COVID-19 and devolution themes were chosen from the literature to explore the content to be analysed.

4.3 Results and Discussion

4.3.1 Devolution and Public Health in Zimbabwe

There is a legal basis for a nexus between public health and devolution in Zimbabwe and ultimately ripple effects in practice. These have not been observed in scholarly works, and this knowledge gap is pivotal in the present chapter in bringing out the state of devolution agenda as a panacea for public health disasters in Zimbabwe. The exercise of devolution in Zimbabwe is embedded in the Constitution (see Box 4.1) and the Devolution and Decentralisation Policy (Webinar II, III, 2020). The Constitution of Zimbabwe resonates with the core ideals of devolution.

Box 4.1 Section 264(2) of the Constitution of Zimbabwe Outlining Objectives of the Devolution of Government Powers and Responsibilities

(a) To give powers of local governance to the people by enhancing their participation in the exercise of the powers of the state and in making the decisions that affect them.
(b) To promote democratic, effective, transparent, accountable and coherent government.
(c) To preserve and foster the peace, national unity and the indivisibility of the Republic.
(d) To recognise the right of communities to manage their own affairs and to further their development.
(e) To ensure the equitable sharing of local and national resources.
(f) To transfer responsibilities and resources from the national government to create sound financial bases for provincial and metropolitan councils and local authorities.

Source: GoZ (2013).

The state has a legally enshrined role to play in safeguarding public health as stated plainly in Section 29 of the Constitution of Zimbabwe and Section 76 of the Constitution. Every citizen and permanent resident of Zimbabwe has a right to healthcare, and the state must take reasonable legislative action and other measures, within the limits of resources available to it, to achieve the progressive realisation of the right to healthcare (GoZ, 2013). Section 29 of the Constitution explicates the role of central government in the realisation of public and individual health within the borders of Zimbabwe (see Box 4.2).

Box 4.2 Section 29 of the Constitution of Zimbabwe on the State's Role on Health

(1) The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.
(2) The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution.
(3) The State must take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease.

Source: GoZ (2013)

Devolution has over the recent past years been advocated as a preferable governance model for enhancing health systems (Kimathi, 2017; WHO, 2016). Yet, despite having strong legal framework for health planning, Zimbabwe still lacks an ample governance framework for consistently establishing the basis on how devolution can help achieve inclusive health goals especially during the public health crisis. Although promoting service delivery particularly health in the country may have been implicit in Zimbabwe's devolutionary process, apparently, it was not the primary driver.

The government has budget allocated funds for devolution in line with Section 301(1)(d) of the Constitution since 2019 fiscal. These funds are meant for infrastructure development in water, health, education and roads within all districts across the country. The delivery of these services relies largely on and is determined by the powers and responsibilities of the tiers of governments. The Constitution of Zimbabwe outlines the objectives of devolution of government powers and responsibilities (see Box 4.1) which is thus a measure of recognition of the status of provincial and metropolitan councils and local authorities in health governance in the country. The Rural and Urban Councils Act bestow power on devolved local authorities to carry out health service delivery.

4.3.2 Central and Local Governments' Responses: Decision Space on Health Matters?

Following the WHO's urge to take bold action to contain the spread of COVID-19, (WHO, 2020a, b). Zimbabwean government took a number of measures including a 21-day nationwide lockdown, on 24 March 2020. This sudden announcement became a bombshell to citizens countrywide; however, literature review reveals that some local authorities had notification before that the lockdown measures would be enacted. The national lockdown was premised on Zimbabwe's declaration of the COVID-19 pandemic as a national disaster (notification) in terms of Section 27 of the Civil Protection Act through gazetting of the Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe) (COVID-19) Notice. This is important from the perspective of health governance as the disaster management process in Zimbabwe extends from the national tier to local tiers of governments, with interactions and coordination among various institutions and actors, since the legal instrument also establishes a legal foundation for local authority's intervention.

At the national level, the MoHCC is responsible for providing stewardship and guidance, and at the sub-national level, mainly departments of health are responsible for implementing the orders from the top echelon of government in the delivery of health services. The central government through the MoHCC has led the development of a COVID-19 National Preparedness and Response Plan (CNPRP). As of 6 March 2020, the government has provided ZWL$two million to the MoHCC for implementation of the CNPRP (Ministry of Health and Child Care, 2020). Priority was given to provinces to conduct self-readiness assessments of their isolation facilities and points of entry to strengthen sensitisation and training of districts on COVID-19 as well as procurement of personal protective equipment (PPE). As part of capacity building of MoHCC personnel on case management and infection prevention and control for COVID-19, the government seconded four MoHCC workers and personnel from local authorities to partake on training conducted by the WHO, Africa Centres for Disease Control and Prevention and other partners (GoZ, 2020). For risk communication and coordination, national and sub-national Rapid Response Teams have been activated in all the districts, provinces and cities in addition to two Inter-Agency Coordination Committees and Inter-Ministerial Meetings on Health. In a devolved state, risk communication and coordination is quite easy (VGN International, 2020) as facilitated by express consultations multi-entities of government modelled around local tiers of the government as provided in Chapter 14 of the Constitution of Zimbabwe.

Under the Civil Protection Act, the central government issued guidelines to the local authorities for actions to be undertaken by urban councils and rural district councils and other local entities, such as healthcare and community workers. However, evidence shows that local authorities tended to have limited resources and means to implement these orders (Kosec & Mogues, 2020a) especially to control the spread of infection with mass testing and contact tracing. As such, local authorities were instructed to work together with frontline health workers and local community members such as village health workers (VHW). Most of these personnel

are appointed by the Ministry of Health and Child Care their function is to work with to develop a comprehensive health plan. The COVID-19 pandemic has burdened an already strained healthcare system in Zimbabwe. Given that public health services at central government health institutions are being overwhelmed and overburdened as a result of the phenomenon of rural-to-urban migration, the central government should have a renewed policy thrust of ensuring equitable development throughout the country through accelerated devolution (Kasu et al., 2021: 90).

As earlier mentioned, the local government system of Zimbabwe is premised upon a devolved system as enshrined in the Constitution of 2013. Over the years, the Zimbabwean urban local government institutions have encountered a number of challenges whose implications on healthcare delivery are not only far-reaching but important for understanding their capacity for battling COVID-19 and its concomitant stressors. The challenges are structurally embedded in the socio-economic and administrative dimensions (OECD, 2020). Notwithstanding its profound impact on local governance around the globe (VGN International, 2020), COVID-19 has put local governments in developing countries at the front line in grappling with the negative outcomes of this unprecedented public health (VGN International, 2020) and economic crisis. Local authorities in Zimbabwe have been among the 'first responders' to respond to the COVID-19 pandemic through a number of measures. Local authorities across the provinces have moved swiftly to implement laid national policy of COVID-19 pandemic preventive strategy to protect their local areas (The Herald, 2021). The Beitbridge Rural District Council has been carrying out awareness campaign and ensured that its 16 health centres have nurses professionally trained to handle the increasing COVID-19 cases (The Herald, 2021). The Masvingo City Council has completed the refurbishment of Rujeko Clinic which was designated as the first provincial COVID-19 isolation centre. Zhanda (2020) observes that local authorities have seized the pandemic as opportunity to revamp dilapidated public structures and facilities most of which are of the informal sector businesses. The provincial and district civil protection committees, for example, in Kwekwe and Masvingo, have scaled up public awareness to prevent coronavirus. On 2 March 2020, the Bulawayo City Council held a sensitisation meeting which was attended by 28 healthcare employees drawn from the health centres in the city.

The rationale for devolving the sector was to allow the sub-national governments to design innovative models and interventions that suited the unique health needs in their contexts, encourage effective citizen participation and make autonomous and quick decisions on resource mobilisation and management possible issues.

4.3.3 Local Authorities and the Provision of Health Critical Infrastructure

Critical infrastructure entails facilities, assets, systems, networks and other elements that human society depends on to maintain public health, safety and economic vitality (Pescaroli & Alexander, 2016). Critical infrastructure can also be

defined as goods and services, asset and system which are essential for everyone and important for supporting key societal functions, such as safety, health, security or economic or social wellbeing of people. Examples of critical infrastructure include, inter alia, health and public health, water, waste disposal, energy, emergency services, food, telecommunication and transport. Local authorities in Zimbabwe are essential critical infrastructure providers, and local health systems, like other institutions in Zimbabwe, rely on critical infrastructure. In Zimbabwe, health services are also within the service delivery matrix of the sub-national governments which include the critical infrastructure. As explicated earlier, the RDCs and UCs are mandated by laws to deliver basic services which include, inter alia, public health, WASH services and waste management. These functions underpin the responses against COVID-19, given the centrality of these services to control and prevent infectious diseases and their secondary effects. Thus, the purpose of devolution is to create and strengthen independent levels of government that are mandated to perform defined functions (Muchadenyika, 2015). The Constitution guarantees basic services such as healthcare, water, sanitation and a clean environment (GoZ, 2013) all of which are critical for controlling a pandemic (see Table 4.1). The absence or failure of any of these services can, within a short time, affect the entire segments of society or businesses.

Through the implementation of intergovernmental fiscal transfers, local authorities have been able to address infrastructure development deficits in record time (ZILGA, 2021). Clinics have been built, roads have been rehabilitated, and various service delivery equipment such as refuse trucks, graders and tippers have been procured (ZILGA, 2021). Devolution has led to an increase in health facilities in Zimbabwe. Mberengwa RDC and Gokwe Town have used devolution funds to construct Garinyama Clinic and Mapfungautsi Clinic, respectively. These local authorities like other local authorities countrywide started receiving devolution funds in

Table 4.1 Critical infrastructure and importance to COVID-19 in Zimbabwe

Critical infrastructure	Importance on COVID-19
Health	Health systems capacity and resilience against pandemics (WHO, 2020b) Minimising cumulative mortality rates
Water	Clean water for handwashing (e.g. safe hands campaign) Proper and frequent sanitation and hygiene Recovery phase on secondary impacts of COVID-19
Waste management	Barrier to human-to-human transmission of COVID-19 virus
Transport	
Energy services	
Emergency services	Public safety and security
Telecommunications	Working from home Online education Digital connectivity during lockdown
Housing	Facilitates shelter-in-home measures First line of defence against

2019 (The Herald, 2021). These allocations, however, need to increase so that local authorities can facilitate the people can progressively realise their health rights during COVID-19. As argued by Chikwawawa (2019: 19), devolution in a unitary state contributes to the improvement of efficiency and effectiveness in governance as well as in the delivery of public services.

Essential infrastructure services such as supplies of food, power and water outside health centres have get disrupted and became unavailable. Another major challenge for councils is to mitigate the impact of COVID-19 on their local economies. For COVID-19 response management and planning, the health system needs to consider not only health-related strategies but also the wider systems upon which health institutions depend, inside and outside the health system anchored on local authorities' role to provide essential services.

4.3.4 Fiscal Devolution and Health Services Financing

Undoubtedly, the extent to which sub-state governments have access to and control over revenue or fiscus determines, to a greater extent, their response to local health problems, COVID-19 in particular. The erosion of sustainable service delivery in 2021 was aggravated by the way in which intergovernmental fiscal support is managed, facilitated and allocated. Although the national treasury purports to be in support of devolution by providing financial support, there is no clarity on how financial support is arrived at in the absence of a formula to ascertain accountability and transparency (Marumahoko & Nhede, 2021). The Government of Zimbabwe acknowledges that as the implementation of the devolution is at its peak, local authorities and provincial and metropolitan councils will not have sufficient financial capacities to provide critical services such as water provision, sanitation, health and education devolved to them (GoZ, 2020) because they require funding, with short- to long-term refund tenure. Without any form of support from national government, urban councils continue to perform certain functions such as primary healthcare and library services without being compensated for it (Marumahoko, 2020a: 7). These challenges have been worsened by fiscal centralism, a phenomenon that leads to shortfalls of local authorities' serious powers to raise finance on their own (Chigwata, 2017). This is so because they are wholly reliant on resources from the national government's Ministry of Finance and Economic Development. The question as to whether rural and urban councils are empowered by Zimbabwean law to raise their own revenue is a critical factor which is commensurate with their health service responsibilities which require funds. Councils derive a large number of their revenues mainly from health, education and road grants, property tax, trading accounts and tariffs for services rendered.

The execrable conditions of the local health system on testing and contact tracing, distribution and administration of personal protective equipment (PPE), closure of some hospitals due to lack of proper COVID-19 PPE for health personnel and more importantly release of meagre funds to local authorities indicate that local

authorities in Zimbabwe lack financial support and control. Evidence shows that 5% release of funds in 2020 by the national government to local authorities was insufficient (Chigiya-Mujeni, 2021) despite the fact that the Constitution prescribe that not less than 5% of Zimbabwe's revenue in the national budget be allocated to local authorities in order to improve service delivery. The central government is also devolving finances to local authorities at a slow pace. This negatively affected the performance of rural and urban councils especially service delivery in their jurisdictions. Chigiya-Mujeni (2021) argues that the underfunding of the local health systems was exposed at the onset of the pandemic as most local authorities' health facilities did not have ventilators or oxygen. Clearly, lack of access to finance affects local governments to support their health obligations amidst the COVID-19 pandemic. In 2021, the matter of rural district councils and urban councils being burdened with unfunded mandates has not been given due consideration to minify the burden on councils (Marumahoko & Nhede, 2021) and amends in an environment characterised by a decrement in own revenue sources due to COVID-19-induced lockdown.

In municipal clinics, Marumahoko and Nhede (2021) observed that urban councils have continued to attend to patients including those with symptoms associated with COVID-19 without charging heft amount. This function or role is not self-funding, and rural district councils and urban councils use their own revenue to fund such functions. As such, Marumahoko and Nhede (2021) argue that it is clear that the national government is not working with urban and rural local government in a cooperative, interactive and facilitatory way to realise meaningful service delivery. In addition, taking into account the feeble financial position of local authorities in Zimbabwe, there is a risk of plunging the country into yet another public health hazards. However, the central government has always not only turned to meddle in the operations of the local authorities but to blame urban councils for poor service delivery.

Cuts of public spending as part of central macro-economic policy called austerity and also due to COVID-19 have aggravated rural and urban council's disinvestment which further undermines the capacity and resources of local government. This presents challenges to the democratic accountability and capacity for redistribution of devolution projects (OECD, 2020), which include health services provision such as building clinics and public ablution facilities as well as water, sanitation and waste management infrastructure. At present and in the future, more demand for council services and a significant free fall in council revenues will jeopardise the support on access for many beneficiaries of councils' health and other related services.

4.3.5 Health Entities, Local Autonomy and Decision Space

The local communities of Zimbabwe are bearing the brunt of the COVID-19 pandemic. Local autonomy as put forward by Chigwata and de Visser (2018) generically denotes the extent to which sub-national governments have discretion in

partaking their obligations and duties. Local autonomy prompts discretion to law-making, adopting policies and implementing decisions within a framework of provincial and national laws though subjected to regular supervision. The COVID-19 pandemic has brought about the importance of embracing such local autonomy as a powerful instrument in fighting the pandemic in Zimbabwe.

Devolution enhances efficiency and effectiveness of operations of local COVID-19 frontline institutions, by minimising bureaucracy as levels of decision-making are closer to the citizens. COVID-19 containment measures would be easy to implement and thus control the spread of the virus. The transfer of authority, power and responsibility and the sharing of resources for shaping an inclusive public health policy play a crucial role in COVID-19 containment.

4.3.6 Quarantine, Isolation, Testing and Contact Tracing

Quarantine, isolation and testing have been approved as the core strategies to curtail the spreading of coronavirus (WHO, 2020a). Scientific evidence has shown that the key to responding appropriately to the COVID-19 pandemic is aggressive widespread testing of the community to detect the virus positive cases which allows for effective contact tracing, isolation of those infected for 14 days and monitoring for those cases that progress to more severe illness (Jokwiro, 2020). In order to slow the spread of COVID-19, to reduce pressure on health services, Zimbabwean government has tried with varying degrees of success to follow WHO guidelines to quarantine or isolate international arrivals, isolate moderate and mild cases (in public facilities or at home), institute mass testing, hospitalise severe and moderate cases and trace and quarantine secondary contacts.

The central government, through Statutory Instrument 83 of 2020, compels local authorities to make land or premises available for isolation and quarantine to help on the control and prevention of COVID-19:

> By written order addressed to any local authority the Minister may require such local authority to set aside and make available during the period of national lockdown any land or premises adequate for the quarantine or isolations of more than fifty (50) persons at a time who are infected with or suspected of being infected with COVID-19, and to comply with the directions of any specified enforcement officer for the management of such land or premises. (GoZ, 2020: 453)

Centres for isolation of suspected COVID-19 cases have been initially set up at Thorngrove Infectious Disease Hospital in Bulawayo and Wilkins Infectious Diseases Hospital in Harare (GoZ, 2020). In spite of the fact that MoHCC has continued to strategically establish other isolation facilities in Gweru, Mutare, Kadoma and Masvingo, local authorities have relied upon institutional isolation which includes using public facilities such as schools to supplement isolation centres (The Herald, 2021) rather than self-isolation at home. This has been much necessitated by limited availability and poor quality of health facilities, thus leading to limited compliance of COVID-19 safety protocols.

In terms of testing, Kwak et al. (2020, 4) asserted that the national government has to provide COVID-19 diagnostic kit to the local to boost their responsive capacity. The Zimbabwean health system lacked the capacity to carry out significant countrywide and community-wide testing programme. Rapid antigen diagnostic tests were introduced to reinforce its COVID-19 response, hitting a daily rate of 4000 tests, a fourfold increase reached within just 2 months after the method was launched in November 2020. The rapid tests have been a game changer, according to the Deputy Director Laboratory Services at the MoHCC (WHO Zimbabwe, 2021). Initially, COVID-19 tests were conducted through the standard polymerase chain reaction in a major laboratory in the capital Harare and later decentralised to the provinces. Even then this was hamstrung by shortages in the supply of reagents due to global competition and longer turnaround time for test results. The rapid diagnostic tests have been distributed to clinics in rural areas, and results are received 20–30 minutes (at the minimum), a time reduction from up to 1 week in certain cases when results through the polymerase chain reaction testing had to be sent back to far-flung localities (World Health Organization Zimbabwe, 2021).

While the government has managed to some degree to detect and prevent entry of the COVID-19 through diagnostics and screening health centres, it faced a stumbling block of limited health infrastructure and equipment such as testing kits and a lack of accessibility by grassroots people to testing. Zimbabwe has the National Medical Reference Laboratory in the capital city Harare as the only laboratory that has the COVID-19 diagnostic capacity. Despite an increase in the testing rates, the per capita testing rates have remained very low, below 1.5 tests per 1000 people compared to over 35 in high-income countries, especially as a result of lack of important supplies (World Health Organization Zimbabwe, 2021).

While contact tracing is also crucial to taming COVID-19 transmission chains and curtailing the spread of the virus, with weak sub-state health departments in Zimbabwe, it has become close to impossible. This is different with countries with contact tracing maximum experience, for example, in Pakistan for polio, it has been able to institute systems at the community level (OECD, 2020). Regarding this, it is of the essence for Zimbabwe to recast devolution in line with health governance to respond to and subdue COVID-19 crisis.

4.3.7 Localised Lockdowns

While COVID-19 has become a global public health emergency of high international concern. The Government of Zimbabwe has realised the efficacy of the local-level approach to respond to surging COVID-19 cases, and it turned to ensure that local outbreaks of the virus are managed speedily and effectively. Among the areas that localised lockdown was imposed were Chitungwiza, Kwekwe District in Midlands Province and Kariba and Hurungwe districts in Mashonaland West Province. This approach was critical given an inability by the communities to comply with the shelter-in-home measures (OECD, 2020) coupled with law

enforcement agencies' (national and municipal) capacity to enforce these measures across all areas of the country.

This is also important in combating new COVID-19 variants within the country. The COVID-19 pandemic needs to be fought at a local level due to the nature of the respiratory virus which spreads very rapidly through droplets generated when an infected person coughs or sneezes or through an airborne aerosol. The local people, when there are symptoms of COVID-19 infection, have to voluntarily block the migration of the people to another province or district and start mass diagnosis (Kwak et al., 2020). Therefore, the local government should consider locking down for a certain period of time in the local community. This needs to be strongly accompanied by quarantine as mentioned in the preceding section. Kwak et al. (2020) support this perspective that while carrying out the mass diagnosis, in many instances, the risk of secondary coronavirus infection is very high that the local authorities have to quarantine the confirmed cases strictly and separate uninfected people from the disease.

4.3.8 Community Public Health Actions: Networks and Local-Level Solutions

Zimbabwe has been lacking an organic network in and out of the central government including localising the tracking tasks. Evidently, little has been done in the country to equip and prepare local healthcare institutions and health professionals to competently handle cases of coronavirus (Mackworth-Young et al., 2021). This has pointed out to the importance of devolution to enhancing the government preparedness and managing the pandemic as the roles of local governments and communities are especially important. Many actors (including local people in remote areas) need to participate in order to overcome the threat of COVID-19.

Government community engagement as part of devolution has proved to be important for responding to the pandemic. As put forward by Mackworth-Young et al. (2021: 86) in their empirical study of healthcare workers and communities' viewpoints on COVID-19 and on early pandemic responses in Zimbabwe, community engagement should be an inherent pillar of an endeavour to address COVID-19 in sub-Saharan Africa from the outset, rather than a second thought. This pillar should include openness to feedback from the community and community leaders (Mackworth-Young et al., 2021). Therefore, central government health entities need to engage with communities as active participants of health response efforts, not as mere passive beneficiaries. Community engagement in the form of constructive engagement with local community leadership, mobilising local community surveillance groups as well as working with women and their organisations, worked well in Ebola in West Africa (Boozary et al., 2014). People occupy the centre of health systems and services as they play various roles, as key stakeholders of health; as consumers and recipients of healthcare services; as providers and makers of the

inputs, goods and services for health; as contributors to funding of health systems; and as nationals in shaping and directing the implementation of the policies and standards that build health systems. The bulk number of people in Zimbabwe are de jure nationals only to continue to be omitted from participation in health and social life, whether through bureaucratic authority or centralisation of political power or some sort of socio-economic deprivation. This exclusion escalates when community people are not engaged to provide their input on health plans and policies which leads them to losing access to health services.

4.3.9 Public Accountability and Efficiency: Checks and Balances

Studies have shown that to increase accountability for public healthcare systems, responsibility for healthcare costs needs to be allocated to sub-national tiers of the state, supported by unconditional block grants to local governments and new forms of management of healthcare entities (Bankauskaite & Saltman, 2007). Without devolved governance, corruption will be a stumbling block affecting transparency and accountability.

While corruption is a known and pervasive 'cancer' in Zimbabwe's governance (Chiweshe, 2017), COVID-19 has validated the fact that corruption is deeply rooted in governance matters of the country and rife in public offices. Widespread corruption was revealed in national government including the so-called Drax Scandal, wherein the Minister of MoHCC, Obadiah Moyo, was arrested and charged with corruption case for unprocedurally awarding a $US60 million contract for COVID-19 medical supplies to Drax International LLC which then sold supplies to the government at inflated prices (Chingono, 2020; Zimbabwe Peace Project, 2020a, b). This led to him being fired from the government by the president. The chief epidemiologist Portia Manangazira was also arrested for recruiting her 28 relatives as community health workers in $800,000 COVID-19 awareness programme funded by the Africa Centres for Disease Control and Prevention (Chingono, 2020). The fund was supposed to cater for the training of about 800 community health personnel, but her family members were paid $600 every month. There were other reports of COVID-19 test kits and personal protective equipment donated by UNICEF went missing. Moreover, this occurred at a time when the health system of Zimbabwe is crumbling. Kenya has also experienced corruption during the COVID-19 pandemic where mass graft was under the popular hashtag 'COVID-19 Billionaires', exposing Kenya Medical Supplies Authority for awarding tenders worth billions to dubious companies (BBC News, 2020). This led to inefficiency; supply of sub-standard equipment; hyperinflation of COVID-19 supplies' prices; logistical bottlenecks in medical supply replenishment rates at public health centres in the counties; occasioned shortages in drugs and reagents for COVID-19 intensive care services, treatment and testing; as well as shortages in PPEs for frontline

healthcare workers as reported by Council of Governors together with frontline workers in Kenya (BBC News, 2020). This mis-governance was a result of the lack of devolved health structures with decision-making powers on resource allocation and the power to detect areas of priorities amidst health crisis. Centralisation of decision-making power is a bad recipe for health governance. As Fonshell (2018) puts it, centralisation of power is a catalyst for corruption.

Devolution proponents Pemberton and Lloyd (2008) and Morgan (2006) contend that devolution of power controls corruption and to some extent all forms of inefficiency. Onyango et al. (2012) also contends that devolution puts in place checks and balances in the governance arena. The fact that resources are distributed to local communities makes it easier for them to manage them in a transparent and accountable way. Any abuse of public resources can easily be traced and exposed. In line with the prudent use of public resources, strong local institutions have the potential to accelerate economic growth which in turn promotes national development.

4.3.10 Local Democracy in COVID-19 Control

As put by Louis Brandeis, the US Supreme Court Judge, devolved governance builds 'laboratories of democracy'. During the time of public health crisis like COVID-19, it is no easy task to take measures that do not restrict some fundamental democratic values and human rights. For example, lockdown measures have affected right to education, freedom of movement and economic rights of citizens (Zhanda et al., 2022). While these measures were 'imperative' that have been implemented in many countries around the globe, the Zimbabwean government have failed to keep such measures to a minimum. Of concern is that amidst the COVID-19 pandemic, there have been human rights abuses countrywide in Zimbabwe. It emerged that there was no due sensitivity to grassroots needs as most of the lockdown measures impacted negatively on local people, the majority of whom are vulnerable. Zimbabwe Peace Project (2020a, b) reports human rights abuses in the form of flogging and harassment of citizens by law enforcement agents mainly the Zimbabwe Republic Police and Zimbabwe National Army. There was a need for considering the local people through consultations rather than taking measures without the views of local people. Moreover, the outstretched power being applied by the state indicates the importance of relinquishing its central oversight to local governments and enhances democracy. In this regard, the non-functionality of the judiciary and parliament and formation of participatory mechanisms and structures could go a long way in promoting a participatory democracy in times of COVID-19.

Devolution makes a democracy stronger by giving communities a say in matters of their concern such as health crisis and the way forward. Excessive control of the central government of Zimbabwe coupled with its discretionary powers has stalled swift responses and initiatives against the COVID-19 pandemic. There has been no consultative process, and as such, important decisions could not be made expeditiously.

4.3.11 'Universal' Health Coverage Problematic

Devolution of Zimbabwe's health sector should be about strengthening the entire health system performance from central to local levels. This improves the ability of health systems to provide sustainable health services that are more equitable, inclusive, efficient and responsive to grassroots communities' needs. Evidence indicates that the COVID-19 pandemic has left a number of people in Zimbabwe unable to visit health facilities such as clinics because of the prevention and containment measures and the fear of contracting the virus (WHO Zimbabwe, 2021). This has thwarted health equity by impacting hard on communities and households which are marginalised and vulnerable with limited access to essential health services. These social groups have missed out on essential health services such as maternal, sexual and reproductive health, access to medicines, immunisation and treatment of chronic or non-communicable diseases. It was reported that more than 80% of facilities experienced a decline in uptake of essential health services, leading the Zimbabwean government to channel efforts towards ensuring that people could access and obtain services they need as well as maintaining safety in patients and health workers (WHO Zimbabwe, 2021). The WHO Zimbabwe in conjunction with the Universal Health Coverage Partnership has worked hand in hand with the MoHCC and provided technical assistance to strengthen the delivery of health services at rural and provincial health facilities during the pandemic.

In this regard, devolution improves the robustness and coverage of health sectors and other related sectors to fight against COVID-19. Moreover, this also ensures participation of local communities in the determination of their health priorities within their areas.

4.3.12 The Limitations of Devolution Model on COVID-19 Curtailment

Devolved governance is not without its shortfalls when it comes to battling health disasters. A number of challenges have been experienced during the COVID-19 by the health sector at sub-national level, thus affecting quality service delivery. These challenges are far-reaching and wide-spanning relationships between local authorities and national government, resources, infrastructure and legal framework. The COVID-19 pandemic has brought to light a long-standing problematic on centre-local relations in Zimbabwe. In Zimbabwe, where devolution is still in its initial implementation stage, the COVID-19 pandemic has thrown into even sharper relief the long-standing tensions between the central and local government. The concentration of power has exposed governments' failures in upholding the values of devolution as governments all over the world instinctively entered into '"top-down command and control" mode – centralising even further the decision space in the face of the stark regional differences in the spread and impact of the COVID-19.

Local authorities in Zimbabwe have been bedevilled with monumental challenges which include capacity gaps, human capital deficiency, lack of critical institutional and legal infrastructure and rampant corruption (Marumahoko, 2020). According to Kimathi (2017), the net effect of these challenges is the stagnation of healthcare and even a reversal of some gains according to health indicators. Policymakers and scholarly proponents of devolution claimed that devolution yields improved public accountability, sustainability and the empowerment of the poor and vulnerable groups (Bardhan, 2002) and health coverage. COVID-19 has shown the importance of having a complete recalibration of Zimbabwe's governance procedures and processes.

4.4 Conclusions and Recommendations

The chapter has articulated the public health dividend and efficacy of devolution in the fight against COVID-19. If devolution were fully in place in Zimbabwe, COVID-19 containment measures would have been easy to implement, thus enabling the control of the spread of the virus to successive waves of the pandemic. The ongoing COVID-19 pandemic presents an opportunity to address the historical underperformance of local tiers of the national government in changing and enhancing the resilience of local communities in fighting their local problems, including health crises such as COVID-19. More importantly, it emerged that devolution's success must be measured by its ability to act as a 'governance laboratory', showcasing and experimenting health policies and responses in one local area, district or province for the benefit of the entire country. Thus far, while devolution in Zimbabwe is gaining political impulse, it has lacked institutionalisation in supporting the health functions of the local authorities. Devolution in Zimbabwe has the potential to propel the containment of COVID-19.

The devolution is critical to taming the national disasters that seem to affect regions based on the administrative and political power to command or channel resources towards a crisis of concern. The devolution of power and responsibilities to sub-national tiers of government will ensure the equitable allocation of national resources and the participation of local communities in the determination of and responses to public health emergencies within their area. Nevertheless, in the fight against COVID-19 in Zimbabwe, coordination between the three tiered systems of government is not an end unto itself; it is only enviable to the extent that it brings better outcomes in subduing the COVID-19 and saving lives.

The chapter proposes forward-looking initiatives in building on devolution to create locally tailored solutions that will deliver more health and socio-economic benefits and resilience, if they are tailored to the local context. The challenges encountered during the COVID-19 pandemic have the potential to bring about reflections and lessons as thrusts on devolved governance and not only for the health sector but the whole service delivery system. The chapter also established that an effective liaison between central and sub-national actors is crucial, even with

comparatively little support and resources. To enhance sub-national authorities' and health entities' capacity to battle the COVID-19 pandemic, the central government together with the local authorities needs to operate more closely with each other, to ensure capacity building around the devolved public health system. This strategy, however, draws much on the resilience and ingenuity of involved players that often go above and beyond 'the day job'. In addition, the national government has to support the rural and urban councils in building such institutional capacity, particularly on human resources for health development. In the context of COVID-19, the central government of Zimbabwe should also establish strategies for localised testing systems in the localised lockdowns.

Devolution should stretch towards uprooting the corruption that affects the healthcare system at all tiers of the government as witnessed during the COVID-19 pandemic. Sub-national governments and the devolved healthcare system in Zimbabwe need to espouse individual and aggregate performance reporting and public accountability for the COVID-19 control measures. Despite the fact that all local authorities have different financial standing and budget requirements, still, it would be crucial that the local governments work together to formulate a policy framework with agreed strategies, objectives and plan of action to ensure public health disaster governance.

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