Kuwait Research Journal of
Business Management (KRJBM)

ISSN Print: 2790-6590 | ISSN Online : 2790-6582 Open Access

Service Delivery In Zimbabwean Hospitals: Challenges, Realties And The Way Forward

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Article History
Received: 05.06.2025
Revise : 10.06.2025
Accepted: 21.06.2025
Published: 28.06.2025

DOI:10.61705/KRJBM.1.2.2025.24.42

Keywords: Zimbabwe, hospital service delivery, health system, governance, financing, Primary Health Care, Donabedian Model, Universal Health Coverage, resilience, reform

Abstract: This study examines the evolution, challenges, and current realities of hospital service delivery in Zimbabwe from independence to the present. It traces how political, economic, and social transitions have shaped the health system—from post-independence expansion under the Primary Health Care approach to decline during structural adjustment, and subsequent crises marked by underfunding, brain drain, and infrastructure decay. Despite severe constraints, hospitals remain central to Zimbabwe's healthcare framework, demonstrating resilience and innovation amid adversity. Using the Donabedian Model and the World Health Organization's Health Systems Framework, the paper analyzes systemic issues such as governance, financing, human resources, and policy implementation. It argues that the crisis in hospital service delivery stems not only from resource scarcity but also from institutional inefficiencies and governance deficits. The study concludes that sustainable improvement requires accountable leadership, equitable financing, and people-centered reforms aligned with Universal Health Coverage goals.

Introduction

Healthcare service delivery is one of the most critical pillars of national development and social well-being. In any country, hospitals serve as the backbone of the health system, providing essential medical care, saving lives, and ensuring that populations enjoy the highest attainable standard of health. In Zimbabwe, hospital service delivery has undergone a complex evolution influenced by political, economic, and social transitions since independence in 1980. Once considered a model for health development in sub-Saharan Africa, Zimbabwe's healthcare system now faces deep-seated challenges that compromise its ability to deliver equitable, efficient, and quality services to its citizens. The current realities of underfunded hospitals, shortages of staff and medicines, and dilapidated infrastructure reflect a system under strain, yet also one with resilience, innovation, and potential for reform. At independence, Zimbabwe inherited a racially segregated and urban-biased health system that favored the white minority population while neglecting the needs of the rural majority. However, the post-independence government placed healthcare among its top social priorities, adopting a Primary Health Care (PHC) approach in line

ISSN Print: 2790-6590 | ISSN Online : 2790-6582 Open Access

with the Alma-Ata Declaration of 1978. During the 1980s, massive investments were made in rural health centers, hospital construction, training of health professionals, and maternal and child health programs. This period saw significant improvements in key health indicators such as infant mortality, immunization coverage, and access to healthcare services. However, these early gains began to erode during the 1990s due to economic reforms and structural adjustment programs that constrained government spending and reduced the accessibility of public services [1]. By the early 2000s, Zimbabwe's health system was in crisis. The country experienced severe political and economic instability characterized by hyperinflation, international isolation, and widespread poverty. Public hospitals—once symbols of progress—faced deteriorating working conditions, shortages of essential drugs and equipment, and mass emigration of skilled health professionals. Health workers' strikes became common, and ordinary citizens bore the brunt of declining service delivery. The 2008 cholera epidemic, which claimed thousands of lives, exposed the deep cracks in the public health infrastructure and the collapse of basic service delivery mechanisms such as water, sanitation, and emergency care. The subsequent period of dollarization (2009–2013) provided temporary stabilization and modest improvements in health financing and service delivery, but the underlying systemic weaknesses persisted [2].

Today, the realities of hospital service delivery in Zimbabwe remain complex. While some progress has been made through donor-supported programs and government reforms, the overall quality of care is inconsistent and often inadequate. Hospitals in urban areas such as Harare and Bulawayo tend to have better resources, specialized staff, and access to private funding, while rural hospitals struggle with acute shortages and limited capacity to respond to public health needs. The COVID-19 pandemic further revealed the fragility of the health system, straining already overburdened hospitals and exposing long-standing issues of preparedness, logistics, and staff welfare. Despite these challenges, the resilience of Zimbabwean health workers and communities remains evident through continued service delivery under difficult circumstances. Understanding the state of service delivery in Zimbabwean hospitals requires an in-depth analysis of the systemic, structural, and contextual factors that shape healthcare outcomes. Service delivery is not simply a function of medical competence or infrastructure; it is an interaction of governance, financing, human resources, logistics, and policy implementation. The Donabedian Model (Structure–Process–Outcome) provides a useful theoretical lens for examining the quality of healthcare delivery by linking inputs and processes to patient outcomes. Similarly, the World Health Organization's six building blocks of a health system—service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance—offer a comprehensive framework for assessing the performance and gaps within Zimbabwe's hospital services. These frameworks will guide the analytical discussion throughout this article. The importance of efficient and equitable hospital service delivery in Zimbabwe cannot be overstated. Hospitals represent the highest level of health service provision, serving as referral points for primary and secondary health centers. They are responsible for specialized care such as surgery, maternal and neonatal services, and management of chronic diseases. As such, their effectiveness directly influences public confidence in the health system, patient outcomes, and national progress toward Universal Health Coverage (UHC). When hospital systems fail, the ripple effects are felt across the entire health continuum—from community clinics to tertiary institutions. Therefore, examining the challenges, realities, and possible pathways to improvement is

ISSN Print: 2790-6590 | ISSN Online : 2790-6582 Open Access

crucial for policymakers, health professionals, and citizens alike [3].

This article seeks to provide a comprehensive examination of service delivery in Zimbabwean hospitals by addressing three core dimensions: (1) the challenges facing hospital service delivery, (2) the realities and lived experiences of both providers and patients, and (3) the way forward—policy and strategic interventions to revitalize the system. In exploring these dimensions, the paper will analyze structural issues such as financing, human resources, infrastructure, and governance; assess the impact of socio-economic and political contexts; and propose practical solutions for reform and sustainability. The central argument of this paper is that Zimbabwe's hospital service delivery challenges are not merely the result of resource scarcity, but also of governance and systemic inefficiencies that hinder the optimal use of available resources. Improving hospital services therefore requires more than financial investment—it demands institutional reforms, leadership accountability, community participation, and evidence-based policymaking. The path forward lies in building resilient, transparent, and people-centered health systems capable of delivering quality services even amid economic and political uncertainty. The structure of the paper is as follows: Section 2 provides a historical overview of the Zimbabwean health system, tracing its evolution from the colonial era to the present day. Section 3 introduces the conceptual and theoretical frameworks that underpin the analysis. Section 4 offers an overview of hospital service delivery structures in Zimbabwe. Section 5 discusses the major challenges affecting service delivery, including human resources, infrastructure, financing, governance, and drug supply. Section 6 presents case studies and lived realities within selected hospitals, while Section 7 examines the roles of key stakeholders. Section 8 highlights innovations and best practices that offer hope for improvement, and Section 9 outlines the way forward through policy and strategic recommendations. Finally, Section 10 concludes with reflections on the future of hospital service delivery in Zimbabwe and the pursuit of Universal Health Coverage. In sum, the state of service delivery in Zimbabwean hospitals is a mirror reflecting the broader socio-economic and political trajectory of the nation. While the challenges are immense, the opportunities for reform and innovation remain viable if harnessed through inclusive, well-coordinated, and accountable approaches. The subsequent sections of this article will delve deeper into these dynamics, offering a holistic understanding of both the obstacles and pathways to achieving efficient and equitable hospital service delivery in Zimbabwe.

2. Historical Context of the Zimbabwean Health System

The development of Zimbabwe's healthcare system has been profoundly shaped by the country's political history, economic transformations, and evolving social structures. Understanding the historical trajectory of health service delivery—particularly within hospitals—provides essential context for the challenges and realities faced today. From the colonial period's racially segregated health policies to post-independence reforms and more recent crises, each era has left a distinct imprint on the structure, financing, and equity of hospital services. This section traces that evolution, examining the major milestones, policy shifts, and systemic disruptions that have influenced hospital service delivery from the early 20th century to the present [4].

2.1 The Colonial Legacy (Pre-1980)

During the colonial era (1890–1980), health services in what was then Southern Rhodesia were designed primarily to serve the interests of the white settler minority. Hospitals and clinics were concentrated in urban centers and mining towns, where the white population and formal-sector workers resided. European settlers enjoyed well-resourced hospitals such

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as Harare (then Salisbury) Hospital and Bulawayo General Hospital, which were equipped with modern facilities and staffed by trained European doctors and nurses. In stark contrast, African populations, who constituted the overwhelming majority, were relegated to poorly resourced "Native Hospitals" or mission-based facilities, often located in rural or remote areas. This racially segregated system reflected the broader political and economic inequalities of colonial rule. Public health efforts targeting Africans were largely paternalistic, focused on disease control to protect the white population rather than to promote African well-being. Mission hospitals, established by churches such as the Roman Catholic and Methodist missions, became crucial providers of healthcare for Africans, filling the gaps left by the colonial government. These mission hospitals—such as St. Paul's Musami, Karanda, and Mt. Selinda—laid the groundwork for many of Zimbabwe's rural hospital networks that exist today. However, despite their contributions, they operated under severe financial and logistical constraints, often dependent on foreign missionary funding and limited medical supplies [5]. The colonial health system thus institutionalized inequity. Health services were stratified not only by race but also by geography and economic status. Access to quality hospital care was determined by one's location and social identity, with urban elites benefiting from state-of-the-art services while rural Africans endured preventable diseases and high mortality rates. These structural inequalities created deep-rooted disparities that continued to influence health service delivery long after independence [6].

2.2 Post-Independence Expansion and Early Gains (1980–1989)

At independence in 1980, the new government of Zimbabwe inherited a fragmented and unequal health system. Recognizing the moral and developmental imperative to redress colonial injustices, the government made health a central pillar of its social policy. Guided by the Primary Health Care (PHC) approach inspired by the Alma-Ata Declaration of 1978, Zimbabwe embarked on an ambitious program to expand healthcare access to the rural majority. Significant investments were made in infrastructure, with new rural hospitals, clinics, and health centers constructed across the country. The Ministry of Health and Child Welfare (now the Ministry of Health and Child Care, MoHCC) prioritized the training of nurses, midwives, and community health workers, while also introducing preventive health campaigns such as immunization drives and maternal-child health programs. The government's "Health for All by 2000" vision emphasized equity, universality, and community participation [7].

The results of these efforts were impressive. By the mid-1980s, Zimbabwe was internationally recognized for its successful health outcomes relative to other African countries. Infant and under-five mortality rates declined sharply, immunization coverage rose dramatically, and the proportion of the rural population living within walking distance of a health facility increased substantially. Hospitals, particularly district and provincial institutions, played a key role in supporting the referral system and delivering specialized care. International donors and organizations such as the World Health Organization (WHO) and UNICEF provided substantial support during this period, helping Zimbabwe become a model for health system development in sub-Saharan Africa. However, this period of optimism also carried the seeds of future challenges. The expansion of healthcare infrastructure created recurrent costs that were difficult to sustain. Hospital services were offered at low or no cost to patients, placing a heavy financial burden on the state. As the economy began to slow in the late 1980s, it became increasingly clear that the system's financial base was fragile and heavily dependent on public funding and donor assistance [8].

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2.3 Economic Structural Adjustment and Decline (1990–1999)

The 1990s marked a turning point in Zimbabwe's health sector. Facing fiscal deficits and economic stagnation, the government adopted the Economic Structural Adjustment Programme (ESAP) under the guidance of the International Monetary Fund (IMF) and the World Bank. ESAP aimed to liberalize the economy, reduce public expenditure, and promote market efficiency. However, in practice, the policy had devastating effects on social services, including health. Budget cuts led to the retrenchment of health personnel, the introduction of user fees in public hospitals, and a reduction in government subsidies for drugs and medical supplies. These measures disproportionately affected the poor, who could no longer afford basic healthcare. Hospitals faced serious shortages of equipment, medicines, and maintenance funds, leading to a decline in service quality. Health worker morale plummeted due to stagnant wages and deteriorating working conditions. Furthermore, the HIV/AIDS epidemic emerged as a major public health crisis during this decade. Zimbabwe's infection rates soared, placing immense pressure on hospitals ill-equipped to handle the growing number of patients requiring long-term care and antiretroviral therapy. The combination of economic austerity and the HIV/AIDS epidemic reversed many of the health gains achieved in the 1980s. By the end of the decade, indicators such as life expectancy and maternal mortality had worsened significantly, signaling a deepening crisis in hospital service delivery [9].

2.4 Political and Economic Crisis (2000–2008)

The early 2000s were characterized by political turbulence, economic collapse, and international isolation. The Fast Track Land Reform Programme (FTLRP), contested elections, and sanctions led to a sharp decline in GDP, hyperinflation, and the flight of skilled professionals. Public hospitals—already strained—became dysfunctional. Many health workers emigrated to neighboring countries or overseas in search of better wages, leaving hospitals understaffed and overwhelmed. Hyperinflation rendered hospital budgets meaningless, and basic supplies like gloves, syringes, and drugs became scarce. Electricity and water cuts were frequent, compromising essential services such as surgery, maternity, and laboratory diagnostics. The deterioration reached a critical level in 2008 when a nationwide cholera outbreak killed more than 4,000 people, largely due to the collapse of sanitation and hospital infrastructure. International humanitarian organizations such as Médecins Sans Frontières (MSF) and UNICEF had to intervene to provide emergency services that the state could no longer sustain. This period effectively dismantled much of the health system's institutional capacity built over the previous two decades. Hospitals were no longer safe havens of care but sites of desperation, where patients had to bring their own bandages, food, and even medications. The human toll of this collapse was immense, and its effects are still felt today [10].

2.5 Stabilization and Reconstruction (2009–2013)

The formation of the Government of National Unity (GNU) in 2009 and the adoption of the multi-currency system brought temporary relief to the economy and the health sector. Dollarization stabilized prices and restored some degree of functionality to hospitals. Donor support increased through initiatives such as the Health Transition Fund (HTF), supported by UNICEF, DFID, and other partners. The fund aimed to restore essential services, rehabilitate infrastructure, and improve maternal and child health outcomes. Hospitals began to restock medicines, pay staff in stable currencies, and resume normal operations. The morale among health workers improved marginally, and outpatient attendance began to rise. However, these gains were fragile and heavily dependent on donor funding

ISSN Print: 2790-6590 | ISSN Online : 2790-6582 Open Access

rather than sustainable domestic financing. The period also saw the introduction of new programs such as Results-Based Financing (RBF), which sought to improve hospital performance and accountability through performance-linked incentives. While these reforms showed promise, their long-term sustainability remained uncertain [11].

2.6 Renewed Challenges and the COVID-19 Era (2014–Present)

From 2014 onward, Zimbabwe's health sector entered a period of renewed strain. Economic growth slowed, government debt increased, and donor fatigue began to set in. Hospitals once again faced shortages of drugs, equipment, and qualified personnel. The introduction of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) and the National Health Strategy (2016–2020) sought to revitalize the health system, but implementation was inconsistent due to fiscal constraints and governance challenges. The COVID-19 pandemic, beginning in 2020, further exposed the fragility of Zimbabwe's hospital infrastructure. Hospitals lacked intensive care capacity, ventilators, and personal protective equipment (PPE). Health workers were at high risk and frequently went on strike over poor working conditions and low pay. Nonetheless, the crisis also revealed the resilience of the system and its people: innovations such as local production of PPE, digital health reporting, and community-based awareness campaigns demonstrated adaptive capacity even in adversity. Today, Zimbabwe's hospitals operate in a context of chronic underfunding, intermittent donor support, and ongoing economic instability. Yet, they remain central to the nation's health delivery framework and continue to serve millions of people despite systemic weaknesses. The legacy of history is still visible—infrastructure built in the 1980s still forms the backbone of hospital services, while inequalities rooted in colonial times persist in the urban–rural divide. In summary, the evolution of Zimbabwe's hospital service delivery reflects the broader historical and socio-economic transitions of the country. The post-independence era of expansion and optimism was followed by periods of austerity, crisis, and partial recovery. Each phase left an indelible mark on the structure and functioning of hospitals. While early policies emphasized equity and access, later decades highlighted the consequences of underinvestment, economic mismanagement, and political instability. The current health system thus embodies both the achievements and the failures of Zimbabwe's development journey—an enduring reminder that sustainable healthcare requires not only political will but also stable governance, adequate financing, and societal resilience [12].

3. Conceptual and Theoretical Framework

A solid conceptual and theoretical foundation is essential for understanding the complexities of hospital service delivery in Zimbabwe. The challenges faced by the country's hospitals—ranging from human resource shortages to governance inefficiencies—are not isolated phenomena; they are interlinked within a broader framework of how health systems function and how quality, equity, and efficiency are achieved. This section discusses the key concepts underlying healthcare service delivery and presents the theoretical frameworks that inform the analysis of Zimbabwe's hospital system. It focuses on the definitions and dimensions of service delivery, the application of Donabedian's Model of Quality of Care, the World Health Organization (WHO) Health Systems Framework, and public administration theories relevant to healthcare governance [13].

3.1 Conceptualizing Service Delivery in Healthcare

In public health discourse, **service delivery** refers to the mechanisms through which healthcare services are made available to populations in need. It encompasses the provision of preventive, curative, rehabilitative,

ISSN Print: 2790-6590 | ISSN Online : 2790-6582 Open Access

and palliative care services, delivered through various health facilities such as clinics, health centers, and hospitals. The ultimate goal of service delivery is to ensure that every individual can access quality health services when and where they need them, without financial hardship—a principle aligned with Universal Health Coverage (UHC). In the context of Zimbabwean hospitals, service delivery can be understood as the **interaction between healthcare providers, patients, and the institutional systems** that facilitate care. It includes both tangible aspects (infrastructure, equipment, drugs, staffing) and intangible dimensions (patient satisfaction, ethics, accountability, and professionalism). Effective service delivery thus depends not only on the availability of resources but also on how well those resources are managed and utilized [14].

Key dimensions of healthcare service delivery include:

- **Accessibility** – the ease with which patients can reach healthcare facilities geographically, financially, and socially.
- **Quality** – the extent to which services increase the likelihood of desired health outcomes and are consistent with professional knowledge.
- **Efficiency** – the optimal use of available resources to achieve the best possible outcomes.
- **Equity** – fairness in distribution of services, ensuring no group is disadvantaged based on socioeconomic status, gender, or geography.
- **Responsiveness** – how well services meet patients' expectations, including dignity, prompt attention, and communication.

In Zimbabwe, challenges in hospital service delivery often emerge when one or more of these dimensions are compromised. For instance, a hospital may have skilled staff (quality) but lack essential drugs (efficiency), or it may provide good services in cities (accessibility) but leave rural populations underserved (equity). Understanding these dynamics requires applying analytical frameworks that connect inputs, processes, and outcomes in health service delivery.

3.2 Donabedian's Model of Quality of Care

One of the most influential frameworks for assessing healthcare delivery is **Avedis Donabedian's Model** (1966), which conceptualizes healthcare quality as the product of three interrelated components: **structure**, **process**, and **outcome**.

1. **Structure** refers to the settings, resources, and organizational arrangements through which healthcare is delivered. This includes physical infrastructure, medical equipment, human resources, and administrative systems. In Zimbabwe, structural factors include the condition of hospitals, the availability of beds and equipment, and the adequacy of staffing levels.
2. **Process** relates to the actual delivery of care—the interactions between healthcare providers and patients, adherence to clinical guidelines, and the efficiency of hospital operations. This encompasses diagnostic procedures, treatment protocols, referral systems, and communication within the hospital.
3. **Outcome** reflects the results of healthcare interventions, such as improvements in patient health, recovery rates, and patient satisfaction. In hospital settings, outcomes can be measured through indicators like mortality rates, infection rates, or readmission statistics.

Donabedian's model provides a logical sequence for analyzing healthcare delivery: **strong structures** enable **effective processes**, which in turn lead to **positive outcomes**. However, weaknesses in any component can compromise the overall quality of care. In Zimbabwe, hospitals often face structural deficiencies—aging infrastructure, shortage of medical supplies, and limited human resources—that constrain process efficiency and, consequently, lead to poor outcomes. For example, even well-trained nurses and doctors cannot perform optimally when faced with

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power outages, broken diagnostic equipment, or lack of basic drugs.

Thus, Donabedian's framework helps explain the causal chain linking the physical and organizational realities of hospitals to the actual experience and health results of patients. It underscores the need for comprehensive reform—improving infrastructure, strengthening management, and ensuring adequate resourcing—to achieve quality service delivery in Zimbabwean hospitals [15].

3.3 The WHO Health Systems Framework

Complementing Donabedian's model is the **World Health Organization's Health Systems Framework**, introduced in 2007. The WHO conceptualizes a health system as consisting of **six interrelated building blocks**, each essential for the effective and equitable delivery of health services. These are:

1. **Service Delivery** – ensuring effective, safe, and quality personal and non-personal health interventions.
2. **Health Workforce** – adequate numbers, distribution, and competency of health personnel.
3. **Health Information Systems** – reliable data collection, analysis, and dissemination for decision-making.
4. **Access to Essential Medicines and Technologies** – equitable availability and affordability of medical products.
5. **Health Financing** – sufficient and sustainable funding that ensures access without catastrophic expenditure.
6. **Leadership and Governance** – stewardship, accountability, and strategic direction for the entire system.

The WHO framework emphasizes that these components must work in harmony for the health system to perform effectively. Weakness in one building block affects all others—a reality vividly reflected in Zimbabwe's hospital sector. For instance, underfunding (a financing weakness) leads to shortages of medicines and demotivation of staff (affecting workforce and service delivery), while weak governance results in poor accountability and resource misallocation.

Applying this framework to Zimbabwe, the following observations emerge:

- **Service Delivery:** Many hospitals offer fragmented and inconsistent services, with wide disparities between urban and rural areas. Emergency response capacity and specialized services are often inadequate.
- **Health Workforce:** The persistent emigration of skilled professionals and frequent strikes have created a critical workforce shortage.
- **Health Information Systems:** Although progress has been made through digital initiatives such as the District Health Information System (DHIS2), data quality and usage remain limited.
- **Access to Medicines:** Frequent drug shortages and procurement inefficiencies undermine treatment continuity.
- **Financing:** The government's health budget remains below the Abuja target of 15% of total public expenditure, forcing hospitals to rely on user fees and donor funding.
- **Leadership and Governance:** Bureaucratic inertia, weak accountability mechanisms, and limited community participation have constrained performance.

By using the WHO's health system framework, policymakers can identify priority areas for reform and ensure a holistic approach to strengthening hospital service delivery. The model also aligns with Zimbabwe's national health strategies, which aim to integrate system-wide improvements rather than isolated interventions [16].

3.4 Public Administration and Health Service Theories

Beyond clinical and system-based models, hospital service delivery also depends heavily on the principles of **public administration**, particularly in contexts where healthcare is largely state-provided. Three theoretical perspectives are especially relevant to Zimbabwe's case: **New Public Management**

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(NPM), **Public Service Motivation (PSM)**, and **Good Governance Theory**.

3.4.1 New Public Management (NPM)

NPM emerged in the 1980s as a response to inefficiencies in public bureaucracies. It advocates for market-oriented reforms within the public sector—such as decentralization, performance measurement, and customer-oriented service delivery. Applied to health systems, NPM promotes hospital autonomy, efficiency, and accountability through mechanisms like Results-Based Financing (RBF) and performance contracts.

In Zimbabwe, NPM-inspired reforms have been partially implemented, notably through the introduction of performance-based budgeting and RBF in selected hospitals. These initiatives aim to reward efficiency and improve service quality by linking funding to results. However, their impact has been constrained by inconsistent implementation, weak monitoring systems, and persistent political interference. Nonetheless, NPM principles remain valuable for guiding future reforms toward more accountable and performance-oriented hospital management.

3.4.2 Public Service Motivation (PSM)

PSM theory emphasizes that individuals working in the public sector are often driven not only by monetary incentives but also by a desire to serve society and contribute to the public good. In healthcare, this motivation is crucial, as the profession demands compassion, ethics, and commitment under often challenging conditions. Zimbabwean health workers have consistently demonstrated remarkable resilience and service ethos despite low salaries, poor working conditions, and limited resources. Understanding and nurturing PSM through recognition, professional development, and supportive leadership can significantly enhance hospital performance.

3.4.3 Good Governance and Accountability

Good governance theory stresses transparency, participation, and accountability as central to effective public service delivery. In hospitals, this translates to responsible leadership, community engagement, ethical decision-making, and anti-corruption mechanisms. Zimbabwe's health sector has at times suffered from weak governance, resulting in resource misallocation and low public trust. Strengthening governance at hospital and ministry levels—through clear reporting systems, stakeholder participation, and independent oversight—is therefore vital for rebuilding confidence and improving outcomes.

3.5 Integrating the Frameworks

The conceptual frameworks discussed—Donabedian's Model, WHO's Health System Building Blocks, and public administration theories—together offer a comprehensive analytical lens for understanding hospital service delivery in Zimbabwe. Donabedian's model captures the micro-level dynamics of quality within hospitals, the WHO framework contextualizes system-wide interdependencies, and governance theories address the macro-level institutional and managerial environment.

In combination, these frameworks illuminate the multiple dimensions of Zimbabwe's hospital challenges:

- **Structural weaknesses** (poor infrastructure, inadequate equipment) undermine the foundations of quality care.
- **Systemic inefficiencies** (financing gaps, workforce shortages) disrupt service continuity.
- **Governance failures** (corruption, lack of accountability) erode trust and performance.

A holistic approach that addresses all these levels simultaneously is necessary for meaningful improvement. Effective hospital reform in Zimbabwe must therefore combine **technical interventions** (investment in infrastructure and technology) with **institutional reforms** (enhancing management capacity and accountability) and **human-centered strategies** (motivating and empowering healthcare workers). This conceptual and theoretical overview underscores that hospital service delivery in

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Zimbabwe cannot be understood or improved through a single lens. It is the outcome of interacting factors—structural, systemic, and behavioral—that collectively determine quality, equity, and efficiency. The Donabedian and WHO models provide structured approaches for diagnosing weaknesses and tracking progress, while public administration theories guide the design of responsive, ethical, and accountable health institutions. Together, they form the analytical foundation upon which the rest of this article builds, as we move from theory to practice in assessing the real-world dynamics of Zimbabwean hospital service delivery [17].

4. Overview of Hospital Service Delivery in Zimbabwe

Hospital service delivery in Zimbabwe operates within a tiered national health system that seeks to ensure comprehensive, equitable, and efficient healthcare for all citizens. Hospitals represent the upper levels of this system, providing specialized and referral services that complement the work of primary healthcare facilities such as clinics and rural health centers. Despite a well-structured design on paper, the actual functioning of hospitals in Zimbabwe has been constrained by decades of economic decline, underfunding, and administrative inefficiencies. This section provides an overview of the structure of hospital service delivery, types of hospitals, governance arrangements, funding mechanisms, and current utilization patterns.

4.1 Structure of the Health System and Hospital Hierarchy

Zimbabwe's health system is organized in a **referral hierarchy**, consisting of four main levels:

1. **Primary level** – rural health centers, urban clinics, and polyclinics.
2. **District level** – district hospitals serving as the first referral points.
3. **Provincial level** – provincial hospitals offering more specialized services.
4. **Central (tertiary) level** – national referral hospitals providing advanced and specialized care.

Each level is expected to handle cases according to the complexity of care required, with patients referred upwards when services are not available locally. However, the referral system often breaks down due to resource shortages, poor communication, and weak coordination among facilities. As a result, central hospitals are frequently overwhelmed by cases that could be managed at lower levels, leading to overcrowding, long waiting times, and reduced quality of care.

District hospitals (approximately 60 nationwide) form the backbone of Zimbabwe's hospital system. They provide general medical, surgical, obstetric, and pediatric services, as well as laboratory and pharmacy support. Each district hospital supervises several rural health centers, creating a linkage between primary and secondary care.

Provincial hospitals (one per province) serve as referral centers for district hospitals within their catchment area. They offer specialist services in surgery, internal medicine, obstetrics and gynecology, and pediatrics. Examples include Gweru Provincial Hospital (Midlands), Masvingo Provincial Hospital, and Mutare Provincial Hospital.

Central hospitals—such as Parirenyatwa Group of Hospitals and Harare Central Hospital in Harare, and Mpilo Central Hospital in Bulawayo—provide tertiary-level care, advanced diagnostics, and specialist training. They also function as teaching hospitals affiliated with medical schools, contributing to health workforce development. In addition, there are specialized hospitals such as Ingutsheni Psychiatric Hospital and Beatrice Road Infectious Diseases Hospital, which focus on specific areas of care. This hierarchical structure is sound in theory but uneven in practice. Referral systems are poorly enforced, and patients often bypass lower levels due to lack of confidence in service quality or shortages of drugs and staff. Consequently,

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tertiary hospitals become congested, while lower-level facilities remain underutilized [18].

4.2 Categories of Hospitals: Public, Private, and Mission

Zimbabwe's hospital network comprises three main categories: public (government-owned), private, **and** mission (faith-based) **hospitals.** Each category plays a distinct role in service delivery and caters to different population groups.

Public Hospitals

Public hospitals, under the Ministry of Health and Child Care (MoHCC), constitute the majority of hospital infrastructure in Zimbabwe. They are financed primarily through government budget allocations, user fees, and, to a limited extent, donor support. These hospitals are mandated to provide services to all citizens, especially low-income and rural populations. However, they are plagued by chronic underfunding, staff shortages, and dilapidated infrastructure. As a result, service quality varies widely, and patients often face long waiting times and shortages of essential drugs.

Private Hospitals

Private hospitals cater mainly to middle- and high-income patients who can afford medical insurance or out-of-pocket payments. Examples include Avenues Clinic, Trauma Centre, and Mater Dei Hospital. These institutions tend to have better infrastructure, higher staff retention, and access to advanced medical technologies. However, their services are prohibitively expensive for the majority of the population, resulting in an inequitable distribution of healthcare access. The private sector also attracts a significant proportion of experienced medical professionals, contributing to a "brain drain" from the public sector.

Mission and Faith-Based Hospitals

Faith-based and mission hospitals, managed by religious organizations such as the Roman Catholic Church and the Salvation Army, play a critical role, particularly in rural and remote areas where public services are limited. Many of these hospitals predate independence and have a strong reputation for community-oriented care. Examples include Karanda Mission Hospital in Mashonaland Central and Howard Hospital in Mashonaland East. They often operate under joint agreements with the government, receiving partial funding and staff secondments while maintaining their own governance structures. Despite resource constraints, mission hospitals are often praised for maintaining higher standards of service delivery, motivated staff, and ethical leadership. Together, these three categories form a mixed healthcare delivery system where the public sector dominates in volume but the private and mission sectors often outperform it in quality and efficiency [19].

4.3 Governance and Management Structures

The governance of hospitals in Zimbabwe is centralized under the MoHCC, though certain elements of decentralization have been introduced over time. The **Permanent Secretary** of the MoHCC provides policy direction, while the **Health Services Board (HSB)** manages human resources. Hospital management is typically led by a **Medical Superintendent** (for district hospitals) or **Chief Executive Officer** (for central hospitals), supported by senior management teams including directors of nursing, finance, and pharmacy. While the system is structured, governance remains a significant weakness. Decision-making is often bureaucratic, with limited autonomy granted to hospital managers to allocate resources, procure supplies, or hire staff. Delays in budget disbursements and centralized procurement procedures frequently paralyze operations. Moreover, political interference and lack of accountability in hospital administration have undermined trust and efficiency. Some hospitals have experimented with Hospital Management Committees **and** Boards of Trustees to enhance oversight and community participation, but

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these structures often lack financial authority and independence. Effective hospital governance requires a balance between **central oversight** for standardization and **local autonomy** for flexibility. In Zimbabwe, this balance has been difficult to achieve, resulting in a mismatch between policy intent and operational realities [20].

4.4 Financing and Resource Allocation

Financing remains one of the most critical determinants of hospital service delivery in Zimbabwe. The health sector has consistently received less than the **15% Abuja Declaration target** of the national budget, often hovering around 10–12%. This underfunding translates into chronic shortages of medicines, delayed infrastructure maintenance, and poor staff remuneration.

The major funding sources for hospitals include:

1. **Government budget allocations** – covering salaries, basic operations, and capital projects.
2. **User fees** – paid by patients for consultations, admissions, or procedures.
3. **Donor funding** – particularly for disease-specific programs such as HIV/AIDS, tuberculosis, and maternal health.
4. **Health insurance and out-of-pocket payments** – primarily in urban private hospitals.

While user fees are intended to supplement operational budgets, they often create barriers for the poor, leading to inequitable access. Moreover, the financial autonomy of hospitals is limited, as revenues collected must typically be remitted to the central treasury before being reallocated—a process that undermines efficiency and responsiveness. Donor funds, while vital, tend to be **vertical and project-based**, focusing on specific diseases rather than systemic strengthening. This can lead to fragmentation, where hospitals may receive support for HIV testing but not for basic supplies like gloves or linen. A sustainable financing model remains elusive, as economic instability continues to erode government revenues and public trust.

4.5 Human Resources for Health

Zimbabwe's hospitals depend heavily on a dedicated but overstretched health workforce. The country trains high-quality professionals—doctors, nurses, pharmacists, and laboratory scientists—but faces persistent **brain drain** due to poor remuneration and working conditions. Thousands of healthcare workers have emigrated to the United Kingdom, South Africa, and other countries in search of better opportunities. The staffing situation varies by level: central hospitals often retain specialists due to training links with universities, whereas rural and district hospitals rely primarily on general practitioners and nurses. The shortage of specialists in rural areas has forced many patients to travel long distances for treatment, undermining equity and timely care. Frequent industrial actions by doctors and nurses reflect frustration with inadequate pay and lack of professional development opportunities. Despite these challenges, the resilience of Zimbabwe's health workforce remains a key strength of the system. Many health workers continue to serve under difficult circumstances, driven by professional ethics and community commitment.

4.6 Patterns of Service Utilization and Access

Hospital utilization in Zimbabwe reflects deep socio-economic and geographic disparities. Urban residents generally enjoy better access to hospitals, both public and private, while rural communities face logistical and financial barriers. Transport costs, distance, and shortages of ambulances limit the ability of rural patients to seek timely care. Public hospitals experience heavy patient loads, especially in emergency and maternity wards. In contrast, private hospitals cater to a smaller, more affluent clientele but deliver services with greater efficiency and comfort. Mission hospitals often serve as lifelines for rural

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communities, handling high volumes of patients despite limited resources. Out-of-pocket expenditure remains high, estimated to contribute more than 30% of total health spending. This places a heavy financial burden on households, leading some patients to delay seeking care or resort to traditional medicine. Access to specialized care—such as oncology, renal dialysis, and intensive care—is particularly limited, concentrated in a few urban hospitals. Overall, Zimbabwe's hospital service delivery system is well-structured in design but fragile in implementation. The country has an extensive hospital network covering all provinces and districts, yet the potential of this infrastructure is undermined by systemic inefficiencies. Underfunding, governance weaknesses, and human resource shortages have constrained service quality and equity. The private and mission sectors help fill critical gaps but contribute to a fragmented and unequal system. The overview reveals that improving hospital service delivery in Zimbabwe will require more than physical rehabilitation; it demands structural reforms in financing, management, and accountability. The next section examines these challenges in greater depth, unpacking the key factors that hinder effective hospital service delivery across the country [21].

5. Key Challenges Affecting Service Delivery in Zimbabwean Hospitals

Despite Zimbabwe's well-established hospital network, the delivery of quality health services faces numerous and interrelated challenges. These challenges are structural, systemic, and human-centered, often reflecting the combined effects of economic decline, political instability, and resource mismanagement. This section examines the main obstacles to effective hospital service delivery, providing a detailed analysis of the realities on the ground.

5.1 Inadequate and Deteriorating Infrastructure

One of the most visible challenges in Zimbabwean hospitals is **aging and poorly maintained infrastructure**. Many hospitals, particularly district and rural facilities, were constructed decades ago and have not undergone significant renovation or expansion to meet the growing population's needs. Key infrastructural issues include:

- **Aged buildings and overcrowding:** Many hospitals have outdated wards and limited bed capacity. Overcrowding in maternity, pediatric, and emergency units is common, often forcing patients to share beds or lie on the floor. Central hospitals such as Harare and Mpilo frequently operate at 150–200% of capacity, creating an environment prone to nosocomial infections and reduced patient privacy.
- **Limited diagnostic and treatment equipment:** Critical medical devices such as X-ray machines, ultrasound units, and laboratory analyzers are often in short supply or malfunctioning due to lack of maintenance. Rural hospitals frequently lack even basic equipment, forcing referrals to higher-level facilities.
- **Unreliable utilities:** Hospitals face frequent electricity outages and water shortages. While some tertiary facilities have backup generators, district and rural hospitals often do not, compromising surgery, refrigeration of vaccines and blood, and overall hygiene.
- **Inadequate transport and ambulance services:** Patient referrals and emergency transport are severely constrained by a shortage of ambulances and poor road infrastructure. This limits timely access to care, especially in rural areas, and contributes to preventable morbidity and mortality. Infrastructure challenges are compounded by inconsistent maintenance and limited capital investment. Government funding for capital projects has been insufficient, and donor assistance tends to focus on disease-specific programs rather than systemic infrastructure development. The result

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is a hospital network that exists in name but cannot consistently deliver safe and timely services.

5.2 Human Resource Shortages and Workforce Challenges

Human resources remain a critical constraint in Zimbabwe's hospitals. While the country has historically trained high-quality health professionals, several factors have led to **persistent shortages and uneven distribution**:

- **Brain drain:** Economic instability and low remuneration have driven many doctors, nurses, and allied health professionals to migrate abroad. The UK, South Africa, and Australia remain major destinations for Zimbabwean medical professionals, exacerbating workforce gaps in both urban and rural hospitals.
- **Uneven distribution:** Specialists are concentrated in urban and central hospitals, leaving district and rural facilities staffed primarily by general practitioners and nurses. This imbalance affects access to specialist care such as surgery, obstetrics, and intensive care.
- **Staff morale and retention:** Poor working conditions, delayed salaries, and limited professional development opportunities contribute to low morale. Frequent industrial actions reflect worker frustration and disrupt service continuity.
- **Workload and burnout:** Overcrowding and understaffing increase the workload for remaining staff, leading to fatigue, errors, and diminished quality of care. In some cases, nurses and junior doctors are forced to cover multiple wards or work extended hours without adequate supervision.
- **Training and capacity gaps:** Continuous professional development opportunities are limited, particularly for rural health workers. Lack of training in modern clinical protocols, infection prevention, and management techniques reduces efficiency and patient safety. Addressing these challenges requires a multi-pronged approach: improving remuneration and incentives, creating retention strategies for rural areas, expanding training capacity, and ensuring supportive working environments.

5.3 Inadequate Financing and Resource Allocation

Financial constraints are a fundamental barrier to hospital service delivery in Zimbabwe. Limited government funding, dependence on out-of-pocket payments, and inconsistent donor support have created a precarious financial environment:

- **Underfunding:** Health sector allocations rarely meet the recommended 15% of total government expenditure (Abuja Declaration), often hovering around 10–12%. Hospitals face chronic shortages of essential drugs, consumables, and maintenance funding.
- **Fragmented funding streams:** Donor and vertical program funding are often disease-specific (e.g., HIV/AIDS, malaria, TB), leaving general hospital services under-resourced. This leads to skewed priorities and neglected areas such as surgical care, mental health, and emergency services.
- **Inefficient resource use:** Bureaucratic procurement procedures, delays in budget disbursement, and mismanagement of funds reduce the effectiveness of limited resources. Hospitals frequently experience stockouts of drugs and medical supplies, undermining both access and quality.
- **Dependence on user fees:** To supplement funding, hospitals rely on patient fees. While these fees help cover operational costs, they create financial barriers for low-income patients, increasing health inequities. In extreme cases, inability to pay results in delayed treatment, worsening health outcomes. Sustainable financing solutions require increased government allocation, improved financial management systems, and equitable funding models that reduce reliance on out-of-pocket payments while enhancing hospital autonomy and accountability.

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5.4 Governance, Leadership, and Management Weaknesses

Hospital governance and leadership in Zimbabwe present another major challenge. Effective governance is essential for efficient resource allocation, accountability, and service quality, yet the following weaknesses are evident:

- **Centralized decision-making:** Hospital managers often lack autonomy over budgets, staffing, and procurement. Centralized control delays critical operational decisions, reducing responsiveness to local needs.
- **Limited accountability:** Weak oversight mechanisms and political interference allow mismanagement of resources, corruption, and nepotism to persist. Public confidence in hospital management is often low.
- **Ineffective strategic planning:** Many hospitals operate reactively rather than proactively. There is limited use of health data and performance indicators to guide planning, monitor outcomes, or improve efficiency.
- **Poor stakeholder engagement:** Community participation in hospital governance is minimal. Hospital Boards or Management Committees, where they exist, often have advisory roles without real authority, reducing transparency and community trust. Strengthening governance requires empowering hospital managers, instituting clear accountability frameworks, enhancing data-driven decision-making, and promoting community involvement in hospital oversight.

5.5 Access, Quality, and Equity Challenges

Even where hospitals exist, **access to care, service quality, and equity** remain major issues:

- **Geographic disparities:** Rural and remote populations face significant barriers due to distance, poor roads, and limited transport. Many rural hospitals are poorly equipped, forcing patients to travel to provincial or central hospitals for basic services.
- **Quality of care:** Poor infrastructure, staff shortages, and equipment deficits compromise service quality. Infection control is often inadequate, leading to high rates of hospital-acquired infections. Diagnostic delays and treatment interruptions further reduce patient outcomes.
- **Inequity:** Socio-economic disparities affect access. Private hospitals cater to affluent populations, mission hospitals serve underserved areas, and public hospitals are overcrowded and under-resourced. Out-of-pocket payments exacerbate inequities, with the poorest often deferring or forgoing care altogether.
- **Referral system breakdown:** Weak referral networks lead to congestion in central hospitals while district and rural hospitals remain underutilized. Patients bypass primary care due to perceived low quality, contributing to inefficiency and inequity.
- **Patient satisfaction and trust:** Limited communication, long waiting times, and inconsistent care erode patient confidence in public hospitals. This affects service utilization and compliance with medical advice, ultimately undermining health outcomes. Addressing these access and quality issues requires integrated strategies that strengthen primary care, improve infrastructure, expand human resources, and ensure equitable allocation of resources. These challenges are interlinked: poor financing affects infrastructure and staffing; weak governance exacerbates inefficiencies; and inequities in access perpetuate health disparities. Solving them requires a **holistic, system-wide approach** that combines resource investment, workforce development, managerial reform, and policy innovation [22].

6. Realities of Hospital Service Delivery in Zimbabwe: Case Studies and Evidence

Hospital service delivery in Zimbabwe is shaped by structural, economic, and social realities that affect both healthcare providers and patients. While policy documents outline an ideal system, the lived experience within hospitals reveals significant disparities between

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theory and practice. This section examines the realities on the ground, using examples from public, private, and mission hospitals, highlighting challenges, coping mechanisms, and the implications for health outcomes.

6.1 Overcrowding and Patient Flow in Public Hospitals

Public hospitals, especially tertiary institutions such as Harare Central Hospital and Parirenyatwa Group of Hospitals, regularly experience severe overcrowding. Reports indicate that ward occupancy often exceeds 150–200% of official capacity. Key observations include:

- **Emergency and maternity wards:** Patients sometimes share beds, sleep on the floor, or use corridors as temporary spaces. In maternity wards, multiple mothers may share a single delivery bed, increasing the risk of infection and complicating postpartum care.
- **Referral bottlenecks:** Patients from rural and peri-urban areas often bypass district hospitals, either due to lack of confidence in services or absence of essential drugs and equipment. This leads to congestion in central hospitals, with medical staff struggling to attend to large numbers of patients simultaneously.
- **Waiting times:** Outpatient departments often experience extremely long queues. Patients report waiting up to 6–12 hours for consultations, and in some cases, they leave without receiving treatment due to exhaustion or inability to pay fees.
- **Resource strain:** Overcrowding stretches the availability of hospital beds, linen, and essential supplies. Nursing staff are forced to prioritize emergency cases, leaving routine care and patient monitoring compromised. This overcrowding not only affects patient safety but also contributes to staff burnout, increasing the likelihood of errors, absenteeism, and professional dissatisfaction.

6.2 Infrastructure and Equipment Deficits

Case studies from provincial and rural hospitals highlight persistent **infrastructure and equipment challenges**:

- **Harare Central Hospital:** Some laboratory equipment, including X-ray machines and biochemistry analyzers, are outdated or frequently out of service. Patients requiring diagnostic tests are often referred to private facilities or must wait weeks for results.
- **Karanda Mission Hospital (Mashonaland Central):** Despite being better managed than many public facilities, the hospital has limited access to advanced surgical equipment. Elective surgeries are frequently postponed due to power outages or shortages of anesthesia drugs.
- **Gutu District Hospital (Masvingo Province):** The hospital has a critical shortage of hospital beds, and the maternity ward often operates with half the required staff. In addition, frequent water outages affect hygiene and infection control.
- **Ambulance and transport challenges:** In rural areas, patients requiring urgent referrals often have to travel long distances on poor roads, sometimes using private taxis or community vehicles. Delays in emergency care can result in preventable deaths, particularly among obstetric and pediatric patients. Infrastructure deficits are compounded by poor maintenance practices. Equipment is often left idle due to lack of consumables or trained personnel, and hospital buildings deteriorate faster than repair schedules allow.

6.3 Human Resource Realities

Staffing challenges in Zimbabwean hospitals are particularly pronounced in rural and district hospitals. Evidence from multiple facilities demonstrates:

- **Shortage of doctors:** District hospitals often have only 1–2 general practitioners covering multiple wards. Specialists are almost entirely absent outside urban centers.
- **Nursing workforce strain:** Nurses often manage multiple patients per shift,

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including high-acuity cases. At Mpilo Central Hospital, nurse-to-patient ratios in medical wards can exceed 1:30 during peak periods.

- **Staff turnover and morale:** A study of Gweru Provincial Hospital indicated high levels of staff absenteeism and resignations, largely driven by low salaries and poor working conditions. Frequent strikes in 2020–2023 disrupted service continuity, highlighting systemic dissatisfaction among health workers.
- **Use of student and volunteer staff:** Hospitals increasingly rely on medical interns, nursing students, and volunteer staff to fill workforce gaps. While this provides temporary relief, it raises concerns about supervision, patient safety, and quality of care. Despite these challenges, healthcare workers exhibit remarkable resilience. Many staff continue to work under adverse conditions out of professional commitment and community loyalty.

6.4 Financing and Resource Constraints

Financial realities shape patient experiences and hospital operations:

- **Stockouts of essential drugs:** Reports from rural hospitals such as Chikomba and Murewa indicate frequent unavailability of antibiotics, antihypertensives, and insulin. Patients are often advised to purchase drugs from private pharmacies at high cost.
- **User fees as a barrier:** Out-of-pocket payments remain significant. Even small consultation fees or admission charges can be prohibitive for low-income households. In some cases, patients delay seeking care, leading to advanced disease presentation and poorer outcomes.
- **Dependence on donor funding:** Some hospitals, particularly mission facilities, rely heavily on external donors for specific programs (e.g., HIV/AIDS treatment). While this support improves services for targeted conditions, it leaves general care underfunded and creates uneven service quality across hospitals. Financial challenges are exacerbated by economic instability and hyperinflation, which undermine the government's ability to maintain adequate funding and retain skilled personnel.

6.5 Governance and Management Realities

Governance challenges in hospitals manifest in operational inefficiencies:

- **Centralized decision-making:** Hospitals cannot procure essential supplies independently without Ministry approval, leading to delays in service delivery. For example, requests for repair of laboratory equipment can take months for approval.
- **Limited accountability mechanisms:** Public hospitals rarely publish performance metrics, and patients often have no formal channel to lodge complaints. Inefficiencies and mismanagement frequently go unaddressed.
- **Community participation gaps:** Hospital Boards or Management Committees often have nominal roles, limiting oversight and public engagement. This affects trust and reduces community confidence in public hospitals. Some mission hospitals, such as Howard Hospital, demonstrate the benefits of strong governance. They maintain transparent financial systems, engage community advisory boards, and consistently achieve better patient satisfaction compared to public hospitals.

6.6 Patient Experiences and Outcomes

Evidence from patient surveys and interviews reveals the human dimension of these systemic challenges:

- **Delays and unmet needs:** Patients report long waiting times, repeated visits, and referrals to multiple hospitals before receiving appropriate care. Chronic disease management is particularly problematic, with interrupted medication supplies and inadequate follow-up.
- **Perceived quality gaps:** Patients frequently cite poor hygiene, lack of privacy, and insufficient staff attention as reasons for dissatisfaction. In some rural hospitals, patients describe being asked to provide personal linen or food due to hospital shortages.

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- **Financial hardship:** Many households incur catastrophic expenditures to access hospital care, including transport, user fees, and private drug purchases. These costs can drive families into poverty, perpetuating cycles of poor health outcomes. Despite these challenges, patients also report positive experiences in mission and private hospitals, where attentive staff, better infrastructure, and reliable supplies improve outcomes and satisfaction [23].

Fundings
There is no funding support and grant/award for this manuscript.

Declarations

- **Availability of data and materials**

Not applicable.

- **Ethics approval and consent to participate**

Not applicable.

- **Consent for publication**

Not applicable.

- **Competing interests**

The authors declare that they have no competing interests.

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