

Role of faith-based organisations and individuals in provision of health services in Zimbabwe



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This article reflects on the increasing roles of faith-based organisations (FBOs) and individual followers in the provision of health services in Zimbabwe within the context of declining capabilities of state-funded and state-owned health facilities. In colonial and post-colonial Africa in general and Zimbabwe in particular, FBOs have consistently contributed to the provision of public services and social security. We contend that state fragilities in the Zimbabwean political landscape result in severe public service delivery deficits that are often filled by FBOs and individual followers. The implications for FBOs and individual followers are twofold. Firstly, the increased involvement of FBOs in the production and provision of public services such as education and health services afford FBOs with opportunities and spaces to evangelise. Secondly, and on the downward side, the provision of health services can often be expensive and diverts attention from the core business of these religious organisations. The article reveals that in the context of economic and governance crises, FBOs play an increasingly momentous role in providing health care services in Zimbabwe. The article focuses on Zimbabwe during the crisis periods of 2007–2009 and 2018 up to the current (2022) socio-economic and political declines, poor governance, and the subsequent fragilities in the state.

Contribution: Faith-based organisations assume increasing roles in the provision of health services in place of failing states. Those increased roles provide FBOs opportunities to evangelise. However, FBOs are not a sustainable replacement because they become afflicted with the same financial challenges that bedevil the state.

Keywords: Christian churches; faith-based organisations (FBOs); health services; ill health; individuals; religion; spiritual dimension; state fragility; Zimbabwe.

Introduction

This article reflects on the ever-increasing roles played by faith-based organisations (FBOs) and their members in the delivery of health services in Zimbabwe. In postcolonial Africa, the state often assumes a prominent role in the production and provision of social services including health. Upon attainment of independence, the new African governments invested and played dominant roles in the provision of social services, particularly health and education to the previously excluded or poorly serviced majority black population. We argue that decades into independence, state capabilities to effectively fund and provide health services typically declined. This has resulted in rising crippling service delivery deficits that are fortuitously filled by FBOs including individuals.

The fragilities and public service provision failures of the Zimbabwean state have been well documented by, among others, Atieno, Moyo and Nyang'oro (2022), Muzondidya (2009), and Raftopoulos (2009). The socio-economic and political situation in Zimbabwe deteriorated drastically from 2000 resulting in state fragility and an inability or unwillingness by the state to deliver the essential services such as healthcare (Musekiwa 2016:91). Except for the period of the Government of National Unity from 2009 to 2013, Zimbabwe has encountered some debilitating socio-economic and political declines that led to the drastic reduction of state's abilities to provide essential social security and public services including the health services. The political situation and economic challenges that bedevilled Zimbabwe affected the health delivery system among other sectors. The decline in formal employment levels also contributed to the collapse of the health delivery systems in Zimbabwe. The socio-economic challenges make the poverty stricken, mostly women and children, particularly vulnerable. There have been mixed viewpoints on the

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causes, nature and extent of the declining service delivery capabilities and subsequent deficits.

Religion and wellbeing are interconnected. In Africa at large and Zimbabwe in particular, traditional religion is inextricably linked to healing and well-being (Shoko 2007:33) and 'health issues are also religious issues' (Shanduka & Togarasei 2018:166). The FBOs that are active in the production and provision of health services in Zimbabwe are mainly the mainline Christian churches and their members, the Pentecostal churches and their members, and traditional religion practitioners (Shoko 2007:33).

The germane questions guiding this article are as follows: How do individual citizens, FBOs and their members respond to the service delivery deficits in the health sector? Can the involvement of FBOs be sustainable in the long run? This article is divided into six sections. Following the introduction is the conceptual framework and then health service delivery models in Zimbabwe from colonial to independence era. The fourth section is on the roles of FBOs in the delivery of health care in Zimbabwe. The fifth and sixth sections cover gendered access to health services and the conclusion respectively.

Conceptual framework

States are typically involved in the provision of public services and social security for a number of reasons (Mikesell 2014). Firstly, the private sector cannot provide public goods effectively and at a profit. Public goods are those whose consumption by an individual cannot reduce enjoyment of consumption by any other actor. Secondly, exclusion in consumption is not administratively feasible, making such goods unviable for provision by the profit-oriented private sector. In that regard, the global and national burdens such as control of contagious pathogens, for example, the recent coronavirus disease 2019 (COVID-19) pandemic are often the responsibility of states. Thirdly, unaided individuals also tend to underinvest in health and, hence the need for state intervention. For certain vulnerable categories such as the senior citizens, expectant mothers and infants, access to health becomes a social protection concern requiring state intervention (World Bank 2022).

Generally, state capabilities are measured in three main dimensions: legitimacy, ability to project coercive power, and ability to deliver essential public services. Although all the three dimensions are critical for measuring state capacity, we purposefully focus on service delivery. Service delivery is the dimension that affects the citizens more directly and it relates to governance. A capable state meets the social security and public goods demands from its citizens, ideally from local funding. State provision of health services also ensures that the necessary subsidies are injected such that the cost at the point of consumption becomes free or at least affordable to the indigent members of the society. When a state fails, it is no longer able to meet the public goods demands from its citizens. In that regard, the other

dimensions of legitimacy are eroded and the state often reacts by unduly deploying coercive force in order to rein in dissenting voices.

It is possible that irrespective of state abilities to provide health services, there might remain a section of the population for religious, cultural or other reasons, preferring to access those services from FBOs and private sector providers. Zimstat (2019:67) reports that 'around one third of people in all wealth categories did not seek treatment when they were ill'. Indeed, Shoko (2007) observes that the Karanga of Zimbabwe have views on 'causes of illness and disease, mechanisms of diagnosis at their disposal and the methods they use to restore health'. Some often prefer to seek the services of African traditional healers depending on the ailment. Traditionally, ailments with a spiritual dimension usually require the services of traditional healers. When the state is capable, the FBOs' role in the delivery of health services is necessarily supportive and minimal.

The responses of FBOs, its members and citizens to state inability to deliver health services influence the state civil relations and long-term service delivery quality. Hirschman's (1970) theory postulates that when citizens face a declining quality of service from a firm, organisation or a state, they have two basic response options to express their discontent: they either exit or voice. Exit means that citizens consciously cease to consume the service or good. Voice attempts to improve the service by way of complaining, highlighting the lapses and suggesting the corrective measures required to improve the quality of the service. The degree of loyalty influences the consumer's choice of either voice or exit. Hirschman's (1970) framework provides a powerful and useful tool for analysing how community responses to the declining capacity of the state to deliver public goods might influence the state's response to failure. However, FBOs' provision of services might offer temporary relief to citizens and in a way compromising the voice that might be necessary for the repair of deficiencies in the governance system.

Health service delivery models in Zimbabwe from colonial to independence era

Prior to colonial occupation in 1890, the provision of health was primarily the responsibility of practitioners in traditional medicine. Traditional medicine also encompasses some spiritual dimensions as the causes of ill health were not always primarily biological and mostly having some spiritual dimensions. Traditional healing promoted the health and well-being of Africans. However, the advent of colonialism brought in institutionalised Western-style medicine that augmented and, in some cases, replaced traditional medicine. The European settlers established health institutions primarily to service the European settler community and 'initially the colonial administration did not regard the care of the African population as its responsibility' (Gilmurray, Riddell & Sanders 1979:33). The colonial administration

reluctantly provided 'rudimentary health service for certain sections of African population' due to two compelling and self-serving causes (Gilmurray et al. 1979:33).

The colonial administration had to provide services to Africans to curtail, 'epidemic diseases like smallpox and infectious diseases to control the potential spread to the settler community' and in addition, the settler economy particularly the mining industry 'depended on a health labour force' (Gilmurray et al. 1979:33). Indeed, for Southern Africa:

[T]hreats were made by the authorities of surrounding territories to prohibit the recruiting of labour for Southern Rhodesian mines if measures were not taken to reduce the mortality rate among workers due to poor living and working conditions. (Gilmurray et al. 1979:33)

Early efforts by the colonial government (aided by missionaries) to establish rural dispensaries and hospitals failed because of inadequate funding and trained personnel to operate these outposts. It was not until 1927 when government legalised subventions to missionary organisations that the rural health centres became viable and even began the training of nursing assistants (Gilmurray et al. 1979:33). The government provided services but favoured urban areas at the expense of rural areas, 'offering predominantly curative rather than preventive facilities' and the 'role of the Christian mission was critical in attempting to extend health care services to larger numbers of rural Africans' (Gilmurray et al. 1979:34).

In 1980, the new independent government successfully deracialised the provision of health services and sought to extend these services to the majority of previously excluded indigenous Africans. These health services such as immunisation of infants were offered by the government at no direct cost to the public. However, in 1991, the Government of Zimbabwe implemented a World Bank and International Monetary Fund supported Economic Structural Adjustment Programme (ESAP), that aimed, *inter alia*, to reduce government funding of public services including health. In line with the objectives of ESAP, in 1991, 'the Zimbabwean government began to systematically enforce the collection of user fees for health services which had been introduced earlier in 1985' (Bijmakers, Bassett & Sanders 1996:54). In 1994, the user fees were increased drastically making such services less affordable by the poorer sections of society. Indeed, a quarter of households surveyed by Bijmakers et al. (1996:70), 'indicated that they had reduced clinic or hospital attendance, mostly for minor illness, so as to avoid paying fees'. The effect of cost in reducing access to treatment was also observed in the 2017 Poverty Income Consumption and Expenditure Survey (Zimstat 2019:69).

Since 2000, the Zimbabwean government was sanctioned by the Western countries for 'poor governance and violation of human rights' and also failed to leverage loans and grants from the Bretton Woods institutions due to arrears. The subsequent socio-political and economic declines resulted in

dramatic deteriorations in the delivery of health and education services and basic infrastructure dilapidated due to the lack of maintenance (Musekiwa 2016:91). For example, a cholera outbreak in August 2008 arising from poor quality of drinking water combined with the poor health delivery system resulted in the deaths of more than 4200 people (GoZ 2010:36). The reduced access to public health adversely affected the poorer communities such as farmworkers who had limited sources of income (Mclvor 1995:34). Indeed, Zimstat notes that:

When ill, the poor and poorest people in Zimbabwe were at, 57 percent, slightly more likely to seek treatment in a public health facility than were the non-poor at 48 percent, whereas about 16 percent of non-poor people who were ill sought help in a private clinic, while 7.9 percent of the poor and 5.7 percent of the extremely poor do that and the extremely poor do not afford private (inclusive of mission facilities) health care. (Zimstat 2019:67)

As the funding for public health declined, health professionals began leaving the sector or even emigrating and those that remained got involved in 'incessant strikes that have been witnessed in the health sector throughout the 1990s' (Gaidzanwa 1999:6). Health professionals have been withdrawing labour intermittently since then to date. Indeed, the doctors under the Zimbabwe Hospitals Doctors Association (who traditionally do not strike) went on an industrial action, spasmodically, since 2019. The Government of Zimbabwe frustrated by the junior doctors' strike in 2019, decided to fire the doctors. In turn, the senior doctors being overwhelmed by the increased workload joined in the industrial action in solidarity with the fired junior doctors. This worsened the situation and further crippled the ailing health sector.

Since then, government-funded and operated hospitals remain understaffed and ill equipped as doctors and nurses continue to be incapacitated, lacking the minimum required essentials in order to perform their duties such as the necessary equipment and essential drugs (Atieno et al. 2022; Scott et al. 2022). Nationwide strikes usually paralyse public hospitals; hence the private sector, FBOs including individuals, fills in the gap in order to provide the required health services. The emergence of COVID-19 and its declaration as a pandemic by the World Health Organization on 11 March 2020 strained and exposed the weaknesses of the ailing infrastructure and systems in the Zimbabwean health sector (Scott et al. 2022). The subsequent aggressive recruitment of nurses by the British National Health Service exacerbated the migration of nurses into the diaspora leaving the health sector short of some critical skills.

As recent as June 2022, health professionals went on strike claiming to be incapacitated because the remuneration in Zimbabwean dollars was insufficient to sustain their day-to-day living. Munemo (2022) argues that in June 2022, nurses earned about Z\$30,000 (less than US\$50) and doctors Z\$50,000 (about US\$80). Health professionals preferred payment in United States dollars that retained value under inflationary conditions.

In the Parirenyatwa Group of Hospitals annual report for 2017, the chairman summarises the challenges that faced the public health sector arguing:

It is no secret that ... the broader health systems across the country, faces a myriad of challenges now and into the future. The demands for the services are increasing due to the rise of NCDs and other chronic conditions. The depressed economy on the other hand has made a lot of people to depend on government for support. (Parirenyatwa Group of Hospitals 2018:10)

The United Nations Millennium summit was held in 2000 where 189 member countries set Millennium Development Goals (MDGs). The MDGs were meant to curtail the rising levels of poverty in developing countries. Zimbabwe made progress but did not achieve the MDGs on health. The MDGs paved way for the Sustainable Development Goals (SDGs) which were intended to expand on the foundation laid by the MDGs. We argue that the MDGs specifically, goal number 6 of combating human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), malaria and other diseases is still outstanding more than 20 years later. Due to the impact of COVID-19 that caused havoc around the globe, Zimbabwe might fail to attain the SDGs by 2030. Goal number 3 that specifically emphasises on good health and well-being of citizens might be difficult to achieve. The continued decline in health systems in Zimbabwe is also likely to threaten the country in terms of attaining the SDGs 3.1 of reducing maternal mortality rates by 2030 and the national vision 2040 of transforming Zimbabwe to a modern society.

The poor service delivery of health by the state-funded centres continues to persist. In a debate in Parliament on 25 August 2022, an opposition legislator, Tendai Biti, argued that, 'the country's largest referral public hospital, Parirenyatwa, had run out of essentials including painkillers with patients forced to buy bandages and syringes' (Chibamu 2022b). During the 24 August 2022 debate in Parliament, a Member of Parliament also indicated that, 'in Chipinge, citizens bitten by dogs were being treated for rabies in Mozambique' (Chibamu 2022b). As the economic crises deepen with rising unemployment, some patients who can no longer afford private health care costs migrate to the public sector (Amnesty International 2021:20) effectively increasing demand on the system that is already under severe strain. Health service declines in Zimbabwe ought to be taken within the broader context of persistent state failure. Currently, the declined capacity in health delivery in Zimbabwe causes some people in need of health services to resort to other alternatives to state-supported institutions. The alternatives (including FBOs) offer services at a nominal fee or free of charge.

The roles of faith-based organisations in the delivery of health care in Zimbabwe

Invariably, the poor and marginalised people in society, in particular women and children, suffer from the lack of

service delivery and cope by accessing alternative service providers.

The traditional Christian churches often operate health facilities along the same lines as state-funded facilities focusing on preventive and curative medicine. These FBOs facilities receive grants from government. Of the church operated hospitals, 'twenty-two hospitals are designated district hospitals and also provide national training for primary care nurses, upskilling midwives, state registered nurses and midwives' (Zimbabwe Association of Church-Related Hospitals 2022). According to the Zimbabwe Association of Church-related Hospitals (2022):

Mission hospitals and clinics in Zimbabwe contribute 68% health care delivery in rural Zimbabwe and 35% nationally. Most mission hospitals and clinics are in remote and hard to reach areas and provide services to underserved, marginalized and vulnerable communities. [n.p.]

The mainline churches sponsored hospitals such as the Roman Catholic Church-owned and operated Driefontein in the Midlands province and the Salvation Army Karanda mission hospital in Mashonaland Central province have remained among the few referral centres of choice for patients requiring expensive medical procedures or long-term hospitalisation. In one interview, Dr Thistle of Karanda Mission Hospital (Vinga 2022) indicated that:

[T]he hospital doesn't have enough medicine as well as specialists to attract so many patients, but we try our best to save lives with the little there is. We have patients travelling from as far as Malawi, Mozambique, and Zambia, with the majority coming from Zimbabwe. [n.p.]

These mission-run hospitals are also popular because they charge affordable fees and often provide generous exemptions for user fees when that is deemed appropriate. Substantial exemptions are often offered to the elderly, pregnant mothers and children. In some cases, these mission-operated hospitals have accessed external grants and managed to provide a better or more consistent service than the government-operated hospitals. However, when the economic crises deepened as was the case between 2007 and 2008, the mission hospitals also experienced reduced state funding and subsequent drastic decline in the quality of health care services provided.

Mainline churches are also venturing into the field of herbal medicines to complement and, in some cases, replace modern medicine. The mainline churches typically discourage their members from consulting and receiving services from traditional healers or *n'angas*. In July 2022, the Catholic Order of the Little Children of the Blessed Lady (LCBL) nuns advertised, in a letter, to parishes and 'other people of God', the establishment of the Blessed Hands Herbal Academy at Visitation Makumbi Mission, about 45 km north of the capital, Harare. The academy's teachings for health solutions are allegedly based on indigenous knowledge of herbs, tradition and spirituality (Chirawu 2022). The Academy is affiliated with the Traditional Medicine Practitioners Council

(Blessed Hands Herbal Clinic 2022). The Traditional Medicine Practitioners Council was originally established, run, and dominated by the traditional medical practitioners whose philosophy and approaches were considered inconsistent with Christian values. With the advent of Christianity and hospitals, traditional medicines had been shunned and regarded as primitive and heathen.

Little Children of the Blessed Lady sisters at Makumbi also operate Blessed Hands Herbal Clinic that offers:

[A] 100% Natural Herbal Solutions for Diabetics, Tooth Aches, TB, Losing Weight, Immune boost, Painful and Poor Eyesight, Painful joints, Poor Sex Drive, Weak immune problem, Cyst, Cancer and Skin Disorders. (Blessed Hands Herbal Clinic 2022, n.p.)

The use of easy to source and grow herbs focussing on both disease prevention and cure is a viable alternative to the modern medical approaches and their preoccupation with the curative dimensions.

In addition to the provision of modern medicine through hospitals, the mainline churches are also providing some divine healing services. In the Roman Catholic Church, for example, there has emerged a 'charismatic renewal' guild that champions the divine healing of illness and disease caused by spiritual elements. Kwaramba (2018:64) argues that the Catholic Charismatic renewal movement adds a new dimension to the mainline Catholic Church because the 'charismatic worship is characterized by vibrant masses as well as prayer meetings featuring prophecy aspects of healing and praying in other tongues'. Besides praying for physical healing, the charismatic renewal movements also pray for miracles. A number of prayer groups in the Roman Catholic Church use social media platforms, such as WhatsApp and Facebook to support members in need of intercession to deal with illness and disease. Such divine healing is consistent with the traditional beliefs and requirements by some of the followers.

The Apostolic Faith missions in Zimbabwe also offers spiritually based alternative health care services. Typically, the Apostolic Faith churches perceive illnesses and diseases to have some spiritual and religious causes and hence a shared 'belief that reliance on modern medicines and healthcare services reflects the level of one's faith, and it is generally associated with weak faith' (Maguranyanga 2011:vii).

Shoko (2007) argues that traditional beliefs and practices prevail despite condemnation by Christianity. Traditional healers who base their practice on the ancestral cult have increasingly been accepted as an alternative source of health services. For example, Sekuru Kanengo has through YouTube publications by Sly TV become prominent in the treatment of substance abuse (Tapfumaneyi 2022). Traditional healers such as Sekuru Kanengo fill the gap caused by the government's inability to respond to the emerging scourge of substance abuse especially among the youths. In addition to

divine healing, the traditional healers also use medicines to treat their patients.

The proliferation of platforms such as WhatsApp, Facebook, YouTube and television has promoted the spread of faith-based healing. Some YouTube-based broadcasts and television networks have shared the divine healing sessions. This is also a way of advertising as well as spreading awareness to the public about the services offered by the traditional healers.

Faith-based healing is popular in Zimbabwe for a number of reasons. Firstly, it is consistent with the African traditional religion that identifies four main causes of illness and diseases such as, 'spirits, witchcraft and sorcery, socio-moral causes and natural cause' (Shoko 2007:57). Shanduka and Togarasei (2018:151) note that, 'healing and well-being of individual members are among the major concerns and practices of Pentecostal charismatic churches in Zimbabwe and elsewhere in the world' and that many Zimbabweans seek for deeper causes of illness beyond the 'inadequate' scientific explanations.

[R]eligious teaching and church regulations of Apostolic Faith groups fundamentally shape healthcare-seeking behaviour, and hence the differences in healthcare-seeking behaviour among them can be attributed to differences in religious teaching and church doctrine (regulations) as well as levels of adherence to these teachings and doctrines. (Maguranyanga 2011:vi)

Secondly, in situations of declining access to modern health services provided by the state (often because of declining capabilities as a result of state fragility or failure), government and international agencies exhibit incapacity to protect the poor and vulnerable (Bijmakers et al. 1996:75). Faith-based approaches to health problems become, sometimes, the only and attractive solution to illness and health. As noted by Shanduka and Togarasei (2018:160), modern public health delivery deficits are often associated with an increase in access to and popularity of divine healing. Thirdly, divine healing is an opportunity to evangelise, recruit and convert new members (Shanduka & Togarasei 2018:151).

Arguably, it is unethical for a government to abdicate its mandate to provide key public services such as health and let the indigent fend for themselves or get such services from the non-state actors such as FBOs. In addition, it is also unethical to expose both the patient and the many unregulated service providers to communicable diseases as they lack sufficient facilities and protective equipment.

One possible implication of the greater involvement of FBOs in the delivery of health service in place of the failing state is that it provides temporary relief to those in need of service at the expense of adequate service in the future. In terms of Hirschman (1970)'s voice and exit framework, when citizens receive a poor service, they can voice. Voicing means engaging the service provider with complaints and suggestions, seeking to reconstitute acceptable service delivery standards. However, the chance to halt the decline in the quality and

quantum of health services and repair the system can be risked by third party involvement. In a way, coping by accessing services from the FBOs make the option of voice less attractive. Of course, the other option is to exit. However, the exit option requires resources and is not always accessible to the indigent who need the social services most.

Gendered access to health services

Access to health services in Zimbabwe is unequal along the lines of income, location and gender (Scott et al. 2022). Urban areas often have more accessible and higher level health facilities as opposed to the often underserved rural areas. Private service-providers are also less accessible to the rural populace. Compared to men, women require greater access to health services for 'vaccinations, antenatal care, family planning and labor and delivery' and hence are unduly and negatively affected by failures of the state to provide accessible and affordable health services (Scott et al. 2022). Women are often poorer (Zimstat 2019:50) and therefore, most of them cannot afford the substitute services provided by the corporate enterprise. In addition to the traditional cultural norms and gendered domestic responsibilities (Amnesty International 2021:8), women bear the brunt of caregiving to their offspring, spouses and relatives.

Disease burden in Zimbabwe is also higher among women than men. For example, the HIV prevalence among women was 21.1% in 2005 and falling to 16.7% in 2015, while the prevalence among men during the same periods declined from 14.5% to 10.5% (Zimstat 2019:33). Women and children also require access to sexual and reproductive health at higher levels than men. Pregnant women and girls can, 'shun public healthcare facilities in favour of home-based deliveries because of inadequate health infrastructure, cultural practices and high hospital costs' (Amnesty International 2021:7). Reduced access to maternal health can also bring some indignity on women. In a local government parliamentary portfolio committee on 19 July 2022, MP Joseph Chinotimba, alleged that:

[P]regnant women who are registered with Harare City Poly Clinics are said to be giving birth in front of security guards at the health institutions without any assistance from the health care personnel. (Chibamu 2022a, n.p.)

Pentecostal churches that offer healing by mainly spiritual means have become popular for offering maternal health services to women in periods of reduced services by the state. On 15 November 2019, Zimbabwe's then only national television broadcasting service Zimbabwe Broadcasting Corporation (ZBC) featured a story entitled 'Mbare woman delivers over a hundred babies'. In the story, one Mbare woman Mbuya Esther Zinyoro also known as Mbuya Gwena, a member of St John's Apostolic Church had reportedly delivered around 250 babies in 2 weeks in her two-roomed flat in Mbare. The nearest maternal clinic in Mbare, Edith Opperman had been closed because the health practitioners were on strike. Pregnant women needing assistance from the community clinic during the strike were stranded as the

doors were locked. The pregnant women had to seek other alternatives. Conveniently, Mbuya Gwena's services were free of charge. Mbuya Gwena claims to be doing a national duty by assisting the women in need. Mbuya Gwena claims to function under the power of the Holy Spirit. Her argument is that through the Holy Spirit, she is able to identify and resolve any complications. Mbuya Gwena indicated that it is God who gives her direction and guidance. The women that Mbuya Gwena usually assisted were typically financially disadvantaged.

Ironically, a few days following the story being aired on national television, the First Lady Amai Auxilia Mnangagwa visited Mbuya Gwena in Mbare. The First Lady applauded Mbuya Gwena's work and donated goods such as blankets, rice, sugar, maize meal, cooking oil, salt, washing powder, laundry and bathing soap, hygiene supplies including latex gloves. The provisions were supposedly to make the service provision safer for both the provider and patients. The First Lady went on to say: '*Dai zvaibvira vanoona nezvehutano vauyawo pano vaonawo mabasa anuri kuita aya nemagariro amakaita pano*' (Rupapa 2019). Translated as emphasising that health officials should visit and equip Mbuya Gwena in order to enable her to better perform the midwifery duties. Amai Mnangagwa went further to say, 'it is important for the health officials to assess your work and if possible give you a midwifery certificate' (Rupapa 2019).

The First Lady's gesture brought mixed comments among the public. The community and other civil societies commented that the government was taking them back to the old scenario during colonialism when the traditional midwives (*vana nyamukuta*, in Shona) delivered babies. Because of inadequate infrastructure and workforce trained in modern medicine, in rural areas, traditional midwives play a prominent role in the provision of maternal health. However, in contrast, urban areas enjoy a higher density of modern health facilities and any reduction in service delivery capacity is regarded as unfortunate and unwelcome. The First Lady appeared to be endorsing traditional midwifery which has been discouraged by the World Health Organization. While some 'women interviewed urged the local authority and government to resolve the impasse with its employees, expressing agony encountered until Mbuya Gwena rescued them' (Chipunza 2019). From a gender perspective, pregnant women are most affected by the health crisis for a number of reasons. Firstly, women usually have limited access to resources and opportunities especially in the home. Secondly, women are usually left out in decision making in the household. Lastly, women usually lack access to health information that may lead to using harmful traditional health practice.

Although Zimbabwe still recognises the role of traditional midwives, the World Health Organization guidelines do not recommend maternal health care delivered via traditional birth methods. Women still need health facilities in cases of complications and also for those needing medicine for the prevention of mother to child transmission of HIV.

Conclusion

In the context of economic and governance crises, non-state actors, particularly FBOs and individual followers play an increasingly momentous role in providing health care services in Zimbabwe, filling in the void left by the failing state. Although the FBOs are accessible and deliver health services free of charge or at a nominal fee, they also lack basic infrastructure and resources. Despite providing immediate relief and a necessary service to a small segment of society, the FBOs are not capacitated to replace the state's role in the provision of public health care. The reconstitution of service delivery capacities might involve, in the short term, the capacitation of both the government-funded and FBOs health service providers. There has also emerged a synergy among government, FBOs and individuals in the provision of health services.

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Authors I.M. and N.M each contributed equally to the writing of this research article.

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