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Political conflict and community health in Zimbabwe: Health professionals' perspectives

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Background: Politics is a major determinant of community's access to health. The right to access to health for communities and individuals has been recognised as vital by international bodies and national constitutions. Several studies have considered the negative effects of political violence on community access to health.

Aim: This study aimed to explore the complexities of political conflict in community health praxis.

Setting: This study was conducted in three clinics in Chegutu Urban District, Zimbabwe. The site was particularly chosen because political conflicts therein have rarely been studied in terms of their indirect and subtle effects on community health.

Methods: This study used a qualitative research approach to gain a deeper understanding of political conflict and community health by interviewing 20 health professionals selected through stratified random sampling. The data obtained from these interviews were thematically presented.

Results: From the participants' responses, it became clear that politics determines the nature of community health programmes, and individual access is partisan and contested. Political conflict to some extent increased intra-group conflicts amongst health professionals, leading to non-collaboration in healthcare. Conflict-induced economic decline has led to structural shortages and environmental pollution.

Conclusion: The study findings demonstrate how politicisation of access to health can have detrimental effects on the excluded members of the community.

Keywords: political conflict; community health; violence; social fabric; governing party; opposition party; health professionals; community.

Introduction

Political conflicts are present in every society in different forms. Although defining conflict is debatable depending on the school of thought, broadly speaking, a political conflict is a disagreement within social systems about the security of the people or maintenance of order (see Gennaioli & Tabellini 2019; Skoog 2015). Party political conflict is characterised by dissent (disagreement on political objectives) and antagonism (more or less sabotaging political interests of the adversary) (Skoog 2015:5). Similarly, Davenport et al. (2019:361) note that parties may choose the route of disruption and violence as a strategy of achieving their political objectives. Political parties may oppose each other as a way of preventing each other from political ascendancy, rather than because of real policy differences (Gennaioli & Tabellini 2019:3). In rare cases, political conflict is competitive and has positive outcomes – such as parties seeking to outshine each other in service provision or collaborating in an emergency – otherwise, it remains a zero-sum game.

Research into political conflict in Zimbabwe has a long history. The academic literature on political conflict reveals several forms such as dissent, violence, antagonistic behaviour and sabotage. The research in Matabeleland North Province by McGregor (2002:12) revealed that the government used strategic disorder, by sending some war veterans to hound workers from local authorities, schools and health centres, accusing them of being opposition activists, and 'vetting' new employees on political lines. Other authors found evidence of the governing party-instigated electoral violence in 2000 parliamentary elections (Makumbe 2002:95), 2002 presidential elections and 2008 presidential run-offs (Compagnon 2011; Fitiwi & Kidane 2018; García-Ponce & Pasquale 2015; Kriger 2012). In response, the opposition parties formed 'action committees' to organise mass protests against the establishment (LeBas 2006:428).

Although, since independence, Zimbabwe has had periods of intense political conflicts, the conflict between Zimbabwe African National Union - Patriotic Front (ZANU-PF) (referred to in this article as the governing party) and Movement For Democratic Change (MDC) (referred to as the opposition party) in particular has been protracted (more than 20 years) and has had major effects on community health, which has rarely been given much attention in academic writing. Rather the conflict has been masked with polarised reportage by the media, with the private press supporting the opposition and blaming government corruption for the failures in the health system, and the public media supporting the government's standpoint that pins the blame for health delivery challenges on the opposition's sabotage and support for economic sanctions (García-Ponce & Pasquale 2015:6). Meanwhile, the conflict has cascaded to urban districts, wards and townships, and is marked by polarisation and intolerance. However, the vast majority of studies miss these aspects of the political conflict as presently manifesting at the 'grassroots' level. This has major implications for the knowledge on political conflict and community health nexus, as demonstrated by the study's findings.

Dimensions of community health

Several studies have indicated three dimensions by which community health can be identified: (1) geographical location, (2) specified population and (3) actions. Community health focuses on the physical and psychological welfare of people in a specified geographic area (e.g. town, ward or village) (Massad, Khammash & Shute 2017:189). Goodman, Bunnell and Posner (2014:58) view community health as the status of a distinct group of population. Thus, the community is constituted by people residing in a localised area with similar values and institutions. It also refers to the actions by the government, non-state entities and the private sector to promote and conserve people's health (Green & Mckenzie 2020:1). The actions are mainly aimed at maintaining and improving health and prevention and disaster mitigation (Lahad et al. 2016:4). In sum, actions to protect and improve the health of people living in a particular area, for example, an urban district, ward or suburb, constitute community health.

Community health is mandated by international bodies, national statutes and municipal law. The World Health Organisation (WHO 2014) lists several actions on community health relating to promoting hygiene, providing healthcare and establishing participatory health committees and village health workers. The UN Sustainable Development Goal (SDG) number 3 mandates member states to ensure universal health and well-being as well as provide timelines for the achievement of each indicator within the goal. The Zimbabwean Constitution, Chapter 4, Section 76 (1) provides for rights to access to health for every individual. The Public Health Act (Chapter 15:17), Section 31, Subsection 1(a) affirms that health praxis should consider and adhere to the principles of human rights and, as per Subsection 9 (b), promote health and the 'social

determinants of health.' Thus, in the context of this article, community health involves the principles contained in the previously cited literature, the current international policy and national and local legislative positions.

Several authors have considered the effects of conflict on medical conditions within communities. Besides exposure to violence, political conflicts breed conditions that stunt development. For example, Miller and Rasmussen (2010: 7–8) list such effects as the obliteration of social systems, malnutrition, war-related disabilities, stillbirths and trauma. Catani et al.'s (2010:1176–1191) study in Sri Lanka revealed that children's exposure to the war caused Post-Traumatic Stress Disorder (PTSD), and poor adaptation. Comparably, Canetti et al.'s (2010:225–228) study in Palestine revealed that PTSD and major depression were prevalent amongst an adult population exposed to political violence. Massad et al.'s (2017:189) study in Palestine also found that early exposure to traumatic conditions led to psychiatric disorder for children. In addition to the direct health consequences of violence, Iqbal (2006:634) posits that health enablers such as basic infrastructure – for example, water and transport – are likely to be destroyed as funds are diverted to security and the military (see also Zwi 2004:34). This point is demonstrated by a Nepalese study by Singh (2004:1500) which found that the political conflict decimated the health infrastructure and disrupted health services.

The limited literature on political conflict and health in Zimbabwe has been couched in terms of political violence and individual health needs. A survey by Shemyakina (2014:4) revealed that as a result of political violence, children born after 2000 had low height-for-age, signifying severe trauma and malnutrition. Kidia (2018:1) argues that political violence against opposition party members caused psychological and physical harm to the residents. The harassment of health professionals, who are frontline workers for community health, has led to most of them quitting and moving to other countries causing massive brain drain (Todd et al. 2010:607). Lastly, Fitiwi and Kidane (2018:10) argue that the formation of the opposition party in 1999 posed a threat to the governing party's grip on power and led to a shift towards survival politics, repression and hurried decisions without any regard to the health consequences – all of which posed a risk to the health system.

The article sought to provide a poised narrative on political conflict and community health nexus. To achieve this, it focused on the lived experiences of health professionals and sought to answer some important questions:

- How do health professionals experience political conflict in their work?
- How does political conflict influence community health efforts?
- What are the known and novel consequences of political conflict on community access to health?

Thus far, several studies have expressed political conflict in terms of physical violence. In as much as the researchers acknowledge the episodic direct violence and its impact on community health, the article further extrapolates on a political conflict that is more subtle, almost latent and intricately linked to who in the community has access to health or lack thereof. Whilst previous studies on health revealed the bodily harm, physical or psychological consequences of political conflict, this study sought to further delve into how politics influences access and affect social cohesion and the implementation of community health programmes.

Research methodology

The researchers used a qualitative research approach, which was important in understanding the views of the participants, as the study was subjective and focused on understanding and explaining social relations (Creswell & Poth 2017; Queirós, Faria & Almeida 2017). This approach enabled the researchers to gain a deeper understanding of the participants' 'on the ground' experiences in relation to political conflict and community access to health. In addition, qualitative research produces non-numeric data by concentrating on oral information rather than quantities (Dodgson 2017:356). Thus, the research findings were presented in words and with a deep analysis.

For the study population, the researchers targeted health professionals ($n = 39$), which included nurses, environmental health technicians, counsellors, nurse aides and nutritionists, working at three clinics in Chegutu Urban District, Zimbabwe. The distribution of the population was as follows: Chinengundu Clinic ($n = 12$), Pfupajena Clinic ($n = 12$) and Chegutu Rural District Council (RDC) Clinic ($n = 15$). To collect data, the researchers used stratified random sampling, by choosing a representative population from each clinic (stratum): Chinengundu Clinic ($n = 6$), Pfupajena Clinic ($n = 6$) and Chegutu RDC Clinic ($n = 8$). The clinics are situated in different locations of the town, and the health practitioners were viewed as representing a particular segment of the generic Chegutu Urban District population which had to be represented. For example, whereas Chegutu RDC Clinic was meant to service the rural population, because of its geographical location (located at the offices of RDC, in Chegutu Central Business District [CBD]) it serves the peri-urban population and the surrounding low-density suburbs. Chinengundu and Pfupajena Clinics serve their respective high-density suburbs, where they are located. Thus, these segments of the community have somewhat different experiences on political conflict and therefore varied access to health. Lastly, to gather rich and diverse views, as well as afford every potential participant an equal chance, the researchers randomly chose participants from the three clinics referred to above as the 'stratum'.

Data collection

The researchers used face to face semi-structured interviewing to decode information from the participants.

A semi-standardised interview schedule was prepared, which contained open-ended general questions relating to the health professionals' views on the relationship between conflict and health, their experiences of political conflict in the community they serve, and their observations on the severity of the political conflict and the community access to health. From these generic questions, the researchers then probed the participants to obtain more information on the subject. The researchers opted for the face-to-face interviewing because politics is a sensitive subject in Zimbabwe; therefore, the participants were allowed to prepare and respond in person at places of their choice. The researchers also reframed repeated questions and explained in cases where clarifications were required.

Data analysis

The study used thematic analysis to process data as provided by Kumar (2019:78). This involved listening to recorded conversations and writing down the responses manually into a book. The second step involved reading the responses and identifying broad themes. In the third step, the researchers identified, from the notes, responses that fit into different themes and painted them using different highlighter colours. After identifying the various themes, the participant responses were presented in two ways: (1) similar views were condensed and summarised and (2) interesting and novel responses were recorded verbatim using pseudonyms. The findings were interwoven into the literature to find similarities or differences.

Findings and analysis

Participant findings revealed the complexity of the political conflict in community health issues. Participants mentioned mundane effects of conflict on health such as mental problems, and in the case of political violence, physical injuries leading to disabilities. However, participants' narrative also yielded data that suggested the deeply ingrained nature of politics in the community's access to health. The study also yielded themes to suggest the corresponding increase of intra-group conflicts as a result of political conflicts, the disturbance of social fabric and structural shortages.

Community access to health is partisan

A common view amongst the interviewees was that community health is a politically contested arena and access is based on one's political affiliation. Surprisingly, even bureaucrats were said to be partisan to such an extent that they viewed access to health along political lines, instead of basing it on reality or community needs to accommodate everyone in a given situation. This was confirmed by three participants:

> 'All community health interventions in Zimbabwe are affected by political contestation. Every organisation supporting the community has to undergo some political scrutiny and has to pass through various government organisations – which are

highly political – for approval and operation. Whether it is a health issue or otherwise, political considerations are dominant.' (Leno, male, 43 years)

'In providing essential services there is screening on political lines. Whatever is coming is associated with the governing party of some sort.' (Jessica, female, 37 years)

'In meaningful community health projects, those not part of the governing party are rarely permitted to provide support to the community.' (Makore, male, 29 years)

The narratives point to a sense of entitlement on the part of the governing party, with a nous of 'our thing' mentality. These results are in agreement with those obtained by Cammett (2011:88–93) in Lebanon, where commitment to a party was associated with increased access to medical care. The almost 'schizophrenic' focus on control betrays a sense of 'obligation' to maintain power at 'all costs' and exhibits how pervasive political conflict can be in community health issues. This survival politics disregards the crucial service delivery mandate of the government (Muchadenyika & Williams 2018:840) as the governing party focuses on winning political battles (Masvaure 2018:203).

Participants reported political forces behind the councils' employment of party members in clinics, who mostly lack the requisite qualifications. This happens particularly when vacancies for general hands and nurse aides arise. These political employees lack an understanding of infection control, the general handling of patients and first aid. The result is that the quality of care being rendered to the community is compromised, but other workers lack the power to prevent these deployments. The community suffers as patients are served by non-professional staff. The findings corroborate McGregor's (2002:9–37) research in Matabeleland, which revealed that war veterans disturbed frontline workers and advocated for their firing to employ governing party representatives. The hiring of employees in lower level jobs is consistent with findings by Brierley (2018:1) in Ghana, where politicians interfere in hiring party members in menial jobs, but select professional workers based on merit.

Political conflicts also cascade to the wards, where there are turf wars and a general bias towards a certain area over others depending on the voting patterns. The comments below illustrate the tug of war and political bias in community health needs:

'In some cases, those councillors who are aggressive tend to attract more attention to their community needs as opposed to others. This creates discrimination and unfair situation to residents from other wards.' (Juma, male, 49 years)

'In Chimanimani where the ruling party won, they responded quickly to Cyclone Idai but during the January 2018 Cholera outbreak in Chegutu, where the opposition won, the government responded only after a week.' (Charity, female, 27 years)

'Donations are channelled along political lines and hardly reach the intended beneficiaries. Most politicians want to be associated with success. Thus, most of the medical donations first arrive in urban centres or growth points. Those who are in the rural and peri-urban areas miss out as politicians congregate at the urban

clinics and fight for control of crucial medical supplies.' (Sibongile, female, 54 years)

The above narratives revealed several interesting observations. Political conflicts sometimes cut across party lines as individual politicians fight lone battles for political survival. In Chegutu Urban District, the opposition has control, but there are only three clinics which are situated in wards 2, 7 and 9, and the rest of the residents in other wards access health care in these clinics. In theory, there should be uniformity in the distribution of services, but the case is different as local politicians fight for their survival. The governing party uses its control of central government finances to stifle opposition-controlled urban areas for political gain (Cuneo, Sollom & Beyrer 2017:260). Lastly, every politician seeks to control community resources, for reasons divorced from community development, which they purport to advance. The interference of politicians in community health, by declaring to be elected representatives, impairs the work of the health professionals and also causes conflict amongst them as discussed in the next section.

Intra-group conflict

Intra-group conflict within the workplace occurs amongst colleagues at the same level or between superiors and subordinates (Whitaker et al. 2017:1). This type of conflict may affect the functioning of a health centre and its ability to provide care to the community. Participants reported intra-group conflicts amongst health workers, arising out of different political affiliation leading to lack of collaboration and some interruption of optimal services. For example:

'A nurse was once accused of being an opposition supporter, causing some conflicts with the superiors who reprimanded him. There were also rumours being circulated that at a certain clinic, nurses only attended to opposition supporters and discriminated against the governing party members.' (Juma, male, 46 years)

To some extent, one participant regarded politics as a precursor to inter-group conflicts:

'It is well known that health professionals fear governing party members. These members, in turn, perceive nurses to be opposition supporters. So, certain patients may refuse to be served by a particular nurse whom they regard as an opposition supporter for fear of getting the wrong prescription.' (Faith, female, 36 years)

The results are consistent with data obtained in Cambodia by Witter et al. (2017:14–15) who reported that medical professionals are put under political pressures by their superiors to act in a certain manner. Most health professionals are reluctant to work towards the progress of their careers for fear of spending most of their time and resources on political networking. This hurts many health professionals as they are deterred from reaching their potential and getting the technical grind that enables them to assist in community health.

However, other participants had differing opinions on the source of divisions amongst co-workers, signifying that political conflict has an overhyped impact on health. Intra-group conflicts in the clinics are typically relational, as co-workers may simply have negative relationships with each other, and this affects their ability to deliver health services:

> 'When someone feels that she/he is younger than you, it affects the nurse. Some doctors from the hospital come to the clinic with their expectations. Instead of respecting our offices, they want to emphasise their own rules.' (Sibongile, female, 54 years)

> 'This is a council clinic, and the staff is mixed, some work for the municipality and some were deployed by the ministry. We have different working conditions, and this might lead some to be laidback as they view that those who are well remunerated should have more workload.' (Obadiah, male, 31 years)

In addition, there are task conflicts, where members want to perform the same task. One said:

> 'Sometimes we may have a tug of war and inadequate division of labour. When delegating duties, some prefer some departments to others, maybe because of the knowledge deficit or pressure as some cannot work under pressure so they choose departments where they see relatively few clients, and there is nothing much to discuss.' (Sarah, female, 38 years)

The data speaks to the diversity of origins of conflict amongst health professionals. Task conflict has no significant influence in community health services in a predictable manner, but relationship conflict is associated with employees wanting to leave their current job (Medina et al. 2005). It is only after understanding the nature of these conflicts that one can determine their severity to community health.

Social fabric

Social fabric embraces the concept of families, community relations and social networks (Boessen et al. 2017:62). The social fabric is intensely influenced by contested political histories (Fitiwi & Kidane 2018:15). Consistent with the literature, the participants averred that conflicts disturb the social fabric of the communities. To consolidate their power vis-à-vis the opposition, the governing politicians control national resources for personal gain at the expense of the communities who are deprived of opportunities for mental and physical health. The participants were unanimous that residents were divided along political lines:

> 'There is lack of collaboration in health projects, for example, the community clinic earmarked for Ward 2 in Tiverton area stalled because of bickering and fight for positions in the building committee along political lines.' (Tari, male, 40 years)

As noted previously, social fabric interacts with the political environment (which in this case hinders it). In this case, the political conflict resulted in the abandonment of a clinic project. The community's brief was to coalesce and mould bricks, whilst the council provided other materials. However, the community, divided along political lines, could not cooperate and the project failed to take off. Thus, there are only three public clinics serving an urban population of 50 590. This exceeds the WHO guidelines of 10 000 people per clinic. Private health centres are less helpful as they are run along business lines and mostly cater for middle to high-income earners who are mostly medical scheme members.

Episodic political violence may deter some residents from visiting health centres. Participant narratives revealed that in 2008, there was an escalated political violence to such an extent that the victims were reluctant to visit public clinics for fear of reprisals. Some victims were physically prevented from accessing the health centres to conceal the atrocities. Most were forced into hiding in fear of their lives and the state-sponsored 'mafia' were searching for them. In townships, people were divided along party lines, former friends and relatives turned against each other in an orgy of violence. The cumulative impact of this has been social degeneration and violence-induced trauma. The fact that perpetrators of the violence are well-known and are still around in Chegutu increases the trauma for victims (and most of them heal physically but have never been treated of PTSD) and the spectre of repeated violence by the same offenders as well as a potential physical response by the opposition defending themselves against repression. These findings are in accord with recent studies indicating that violence in Zimbabwe is methodical and political (Dodo, Nsenduluka & Kasanda 2016; Duri 2019; LeBas & Munemo 2019; Nyere 2016). These results also confirm the association between violence and physical and psychological trauma (Kidia 2018). However, these studies rarely focus on the possibility of an uprising by the opposition as a response, using the same modus operandi as the state, and what effect this might have on community health. The January 2019 uprising by the opposition youths in various urban districts in Zimbabwe represents a case of a cycle of violence caused by social decay and the normalisation of violence in the community.

Only a small number of interviewees reported benefits or potential benefits of political conflict to community health. This is in agreement with Skoog's (2015:1–19) theoretically derived definitions of political conflict which showed that multiparty politics may create meaningful competition. Participants reported that political competition through campaigns has led to borehole drilling by political candidates and improved community health through access to clean water. Participants also reported schools' feeding schemes as promoting the physical and mental health of learners. There were some suggestions that the provision of sanitary ware to girls in marginalised areas promotes the good health of women. In some cases, political candidates also pay school fees for the less privileged thereby relieving the parents from stress induced by the inability to shoulder the burden. The differing perspectives may demonstrate the diversity of views amongst the participants or the desire to find something 'positive' in an otherwise overwhelmingly negative situation. This was demonstrated by participant narratives indicating shortages that impede the implementation of community health programmes.

Structural shortages

One unsurprising finding from the study is the incapacitation of community health systems because of structural shortages. Structural shortages pertain to resources that are inequitably distributed, to such an extent that health centres in areas where political elites reside are well equipped and are mostly privately owned, whilst public clinics in townships are underequipped. Political conflicts have gradually bogged down the economy resulting in scarcity of foreign currency and reduced capacity to produce medicine and procure critical material. This has forced the political elites to prioritise their welfare. Participants reported a shortage of almost everything critical to the proper functioning of the community health centres. Examples are medicines, protective clothing, gloves, psychiatric drugs, blankets and health professionals. Participant narratives below validate this:

> 'There is a shortage of supply of every type of pill, even the basic ones are such as paracetamol.' (Zambuko, male, 35 years)

> 'We just write prescriptions to patients and they go to buy from pharmacies.' (Tambu, female, 50 years)

> 'As a Counsellor, I wish to have a consultation room. This clinic lacks space.' (Mandi, female, 32)

This study supports evidence from previous observations by Mashange et al. (2019:8) that political conflict, especially in 2008, led to 'empty shell' clinics. Similarly, Egyptian physicians reported a drug shortage during the political disturbances of 2011 (Abdelrahman et al. 2016:191). However, the findings that conflict increases the propensity for state actors to focus on their survival at the expense of the taxpayer communities as a by-product of conflict has rarely received attention in previous studies.

The domino effect of political conflict-induced economic decline is evidenced by either 'dry taps' or contaminated water and sewer systems constantly bursting. The state has politicised municipal water provision, a case in point being the wrestling of control of water infrastructure from urban municipalities to the Zimbabwe National Water Authority (ZINWA). Participants reported that this has particularly put children in danger of contracting diseases, as the raw sewage flow in the streets. Participants reported increasing cases of diarrheal diseases, typhoid and in some cases cholera as a result of contaminated water provided by the municipality:

> 'Although we do hygiene education, there is still a challenge because municipal water is still to be trusted.' (Memory, female, 45 years)

Resources have been channelled away from constructive efforts to bring water, towards funding political activities. This has led to indirect consequences, such as infrastructure collapse, water contamination and loss of lives, which could have been avoided. Several studies have suggested an association between an increased focus on political fights and the decline in water infrastructure. For instance, Cuneo et al. (2017:260) argue that the governing party's loss of municipal elections in Zimbabwe resulted in the withholding of funds to municipal budgets for urban districts where it had been defeated. These punitive cuts resulted in a termination of water treatment and, ultimately, the transferal of 'raw sewage into the urban centres' main reservoirs' (Musemwa 2008). In line with the previous argument by Mehta and Derman (eds. 2017:7) argue that explicit government actions led to the circumstances in which water-related epidemics such as cholera increased.

Key lessons

These findings assist in the understanding of how politicisation of access to health can have detrimental effects for the excluded members of the community. The focus on political contestations and politics of sabotage, which disturb service provision, lead to critical shortages in health infrastructure. This poses a burden to the residents because most of them travel long distances to overcrowded facilities. There is a need for a deep introspection and a radical departure from confrontational to competitive or cooperative politics that considers the welfare of the vulnerable population as a priority. Whilst political change is desirable, it is the modus operandi of doing the politics that should radically shift towards competition to deliver, rather than efforts to prevent another party from delivering. Community development requires that those who are affected by any policy proposition – the community and frontline health workers – be given the chance to shape the direction of the policy.

Conclusion

Politics and political conflict are intricately linked to community health actions. Using the experiences of health professionals, the paper analysed the extent to which political conflicts have an impact on the community's access to health and community wellbeing. Participant narratives revealed several insights into conflict–health interconnectedness. Access to the community by any organisation seeking to promote health and access to health services and facilities by community members is highly political and contested. During episodic political violence in Zimbabwe, access to health centres has been denied to opposition supporters, with negative effects to their wellbeing. Political conflicts cascade to health professionals as they too may be supporters of opposing political parties. Still, most intra-group conflicts within the health profession are relational or task-oriented and have nothing to do with political conflicts. It is difficult to ascertain how intra-group conflicts have measurable impacts on community health besides the minor grievances from patients who visit the health centres. Political conflicts cause social degeneration as communities are divided along with their political affiliations and rarely collaborate in community health projects. Political repression and violence have tended to solicit a similar response by agitated opposition youths, necessitating further escalation and becoming a vicious cycle. To a lesser extent, politicians have promoted community health during election times – although it is by default and is a form of vote-buying and not conscious

effort to improve the health status of the community, as these are palliative in nature. One unsurprising finding was the effect of political conflict on the economy, which in turn has caused shortages of almost every item needed for health care in clinics and deterioration of the water system which affected water availability and quality.

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