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REVIEW OF Rural Resilience Praxis

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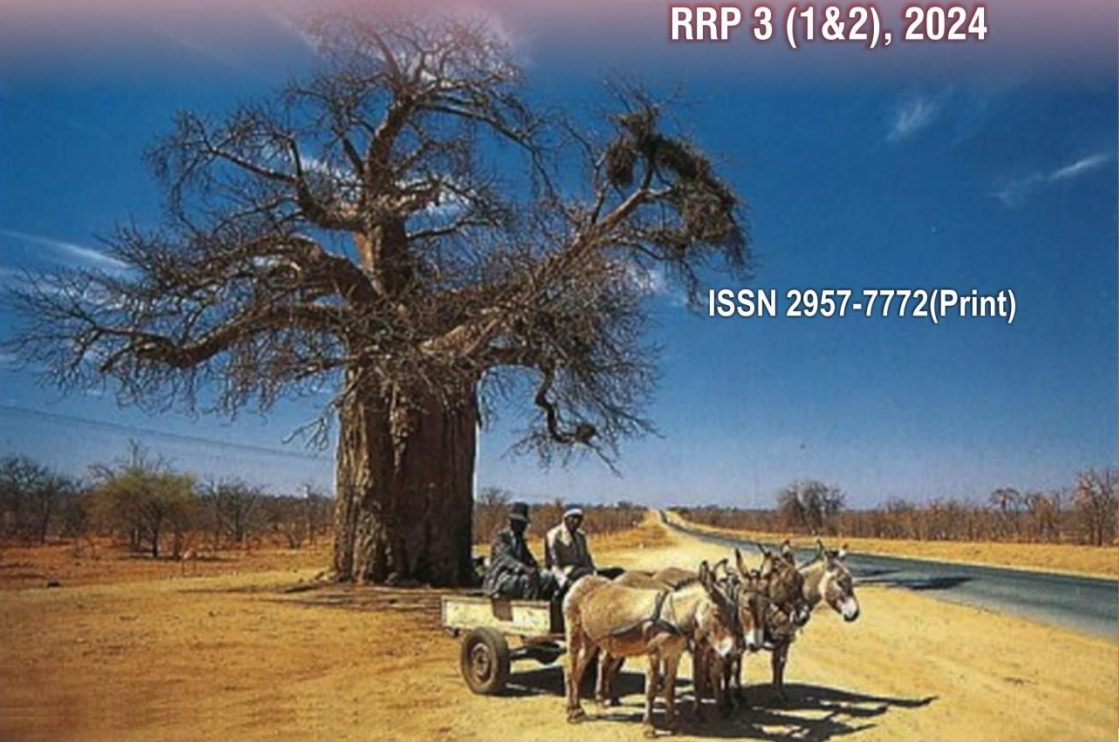

REVIEW OF
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About the Journal

JOURNAL PURPOSE

The purpose of the *Review of Rural Resilience Praxis is* to provide a forum for disaster risk mitigation, adaptation, and preparedness.

CONTRIBUTION AND READERSHIP

Sociologists, demographers, psychologists, development experts, planners, social workers, social engineers, economists, among others, whose focus is on rural resilience.

JOURNAL SPECIFICATIONS

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SCOPE AND FOCUS

In as much as the urban economic trajectory is increasing by each day, the rural economy, especially in many developing countries, still comprises a great proportion of the extractive and accommodation industries. Retaining some spaces as rural areas remains critical given the integral role rural areas play in providing ecosystem services to both wildlife and humanity. In this light, rural resilience as practice beckons for critical studies especially in the face of the ever-threatening extreme weather events and climate change that then impact on the livelihoods and lifestyles of the rural communities. Review of Rural Resilience Praxis (RRRP) comes in as a platform for critical engagement by scholars, practitioners, and leaders as they seek to debate and proffer solutions to the rural sectors' sustainable growth trajectory, which is resilient to the vagaries of climate change. This journal is also aimed at championing the philosophy of the right to be rural. The issue of conviviality between the different constituencies of the sectors, compiled with the competing challenges of improving rural spaces while also making the conservation, and preservation debates matter is the hallmark of this platform of critical thinking and reflection. The journal is published bi-annually.

Guidelines for Authors for the Review of Rural Resilience Praxis

Articles must be original contributions, not previously published and should not be under consideration for publishing elsewhere.

Manuscript Submission: Articles submitted to the *Review of Rural Resilience Praxis* are reviewed using the double-blind peer review system. The author's name(s) must not be included in the main text or running heads and footers.

A total number of words: 5000-7000 words and set in 12-point font size width with 1.5 line spacing.
Language: British/UK English
Title: must capture the gist and scope of the article
Names of authors: beginning with the first name and ending with the surname
Affiliation of authors: must be footnoted, showing the department and institution or organisation.
Abstract: must be 200 words
Keywords: must be five or six containing words that are not in the title
Body: Where the authors are more than three use *et al.*
Italicise *et al.*, *ibid.*, words that are not English, not names of people or organisations, etc. When you use several authors confirming the same point, state the point and bracket them in one bracket and in ascending order of dates and alphabetically separated by semi-colon e.g. (Falkenmark, 1989, 1990; Reddy, 2002; Dagdeviren and Robertson, 2011; Jacobsen *et al.*, 2012).

Referencing Style: Please follow the Harvard referencing style in that:
— In-text, citations should state the author, date and sometimes the page numbers.
— The reference list, entered alphabetically, must include all the works cited in the article.

In the reference list, use the following guidelines, religiously:

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Health as a Rural Development Matter: How Safe and Secure are Rural Populations in Zimbabwe Since 2000

AMOS MILANZI, JAMES MUNAMATI AND JULIET MILANZI[1]

Abstract

This study provides a comprehensive overview of the intricate developmental nexus between health and rural development in Zimbabwe, specifically focusing on the safety and security of rural populations from the year 2000 to the present. The primary objective of this essay is to shed light on the challenges and opportunities that rural communities in Zimbabwe encounter concerning their health and well-being within the broader context of development initiatives. To achieve this, the study adopts a mixed-methods approach, integrating quantitative analysis of health indicators with qualitative investigations into the socio-economic factors influencing rural health. Quantitative data for the study is sourced from the Zimbabwe Demographic and Health Survey, emphasising key health metrics such as contraceptive use, teenage pregnancies, sexual and gender-based violence, HIV&AIDS prevalence, and HIV testing. In tandem with this quantitative approach, qualitative data is collected through interviews and focus group discussions conducted in carefully selected rural communities. The combined findings of this research aim to contribute significantly to a nuanced and holistic understanding of health as a pivotal component of rural development in Zimbabwe. In rural areas, the levels of contraceptive use is slightly lower, at 63%, compared to urban areas, which stands at 71%. The level of HIV testing in rural areas is slightly lower, 35%, compared to the higher rate observed in urban areas, which stands at 38%. It is important to note a significant gender-based disparity, with higher HIV prevalence among women at 17% compared to men at 11%. In rural settings, the prevalence of sexual violence is higher, at 14%, compared to 13% in rural areas. The prevalence of physical violence is higher, at 35%, compared to the slightly lower rate observed in urban areas, which stands at 34%. The prevalence of malnutrition in children is higher in rural areas, at 29%, compared to 22% in urban areas, with the level of vaccination slightly lower in rural areas, at 75%,

[1] Department of Demography Settlement and Development, Faculty of Social and Behavioural Sciences, University of Zimbabwe,

compared to the higher rate observed in urban areas, which stands at 81%. This research's outcomes are expected to be valuable for policymakers, healthcare practitioners, and development agencies, providing evidence-based insights for formulating targeted interventions. The study recommends formulation of effective strategies that can improve the safety and security of rural communities in Zimbabwe.

Keywords: *health, rural development, safe, secure, rural population, post 2000, Zimbabwe*

INTRODUCTION

The persistent global phenomenon of inequitable resource distribution between rural and urban areas, leading to socioeconomic differences, is particularly pronounced in developing countries in the global south. A significant proportion of extreme poverty is concentrated in rural areas, with an estimated 79 percent of those in poverty residing in such settings (World Bank, 2018). In the global context, approximately 736 million people live in extreme poverty, a significant decrease from nearly 2 billion in 1990 (World Bank, 2018). Sub-Saharan Africa, home to about 413 million poor people, experiences a notably higher poverty rate of 41 percent compared to other regions globally (World Bank, 2018). Notably, Africa remains the world's most rural region, with 60 percent of the population living in rural areas, a figure expected to decline to 44 percent by 2050 due to rapid urbanization (UNDESA, 2015). Rural areas often face a scarcity of public investments and lack essential infrastructure, further contributing to social exclusion and the marginalization of large segments of the rural population. Rural development is essential to achieving the 2030 Agenda for Sustainable Development. It is also a reflection of the Agenda's guiding principle of leaving no one behind. This study explores the multifaceted challenges faced by rural populations in Zimbabwe in accessing healthcare services. The general objective of the study was to establish the trends and determinants of health in rural areas of Zimbabwe, using data from Zimbabwe Demographic Health Surveys conducted between 1999 and 2016. The findings aim to contribute to a nuanced understanding of the complexities involved in ensuring equitable health care delivery, particularly in rural settings, and inform potential interventions to address these challenges.

This article is the outcome of a study that sought to investigate the nexus between health and rural development. The study bore the title, Health as a Rural Development Matter: How Safe and Secure are Rural Populations in

Zimbabwe Since 2000.This article gives the background to the study and highlights the research problem. Literature gaps will be identified on Health as a Rural Development Matter in Zimbabwe. It also gives an insight into the objectives which provides direction to the study. The Theoretical framework underpinning the study and the methodology employed will be presented. The major findings and discussion will be presented. The article will end by giving the conclusions and recommendations.

THEORETICAL FRAMEWORK

This study employed the Ecological Systems Theory (EST), as conceptualised by Bronfenbrenner in 1979. Bronfenbrenner (1979) acknowledged that human development unfolds within a complex network of interactions between the individual and the broader society. Consequently, he formulated a model delineating four layers of ecological structures, encompassing direct contacts that initiate with social agents and extend to comprehensive institutional systems. The ecological model intricately dissects the factors influencing access to health while also providing a framework for investigating associated outcomes. Rather than solely focusing on rural residents, the model delves into five potential levels of determinants: individual, interpersonal, organisational, community, and national/policy levels. These determinants operate concurrently at multiple levels.

Figure 1: *The Ecological Systems Theory* (Bronfenbrenner, 1979)

LITERATURE REVIEW

Recognising the evident disparities in the delivery of health services, a global response was triggered, leading to the formulation of the Alma-Ata Declaration in 1978 (Rifkin, 2018). This declaration transformed the landscape of public health by underscoring the significance of Primary Health Care (PHC) as a mechanism to tackle health inequities. In Zimbabwe, the initiation of the PHC program took place in 1982 in alignment with this worldwide initiative. The programme concentrated on enhancing rural healthcare infrastructure, extending immunisation initiatives, addressing diarrheal diseases, and implementing national nutrition programs (Chilunjika and Muzvidziwa-Chilunjika, 2021).

Despite a substantial decentralisation and democratisation of Zimbabwe's health sector during the initial phase of the PHC programme, persistent challenges were encountered (Ray and Masuka, 2017). Notwithstanding, the continual endorsement of the PHC approach in national health strategies, impediments such as skills migration, inadequate investment, and restricted resources impeded its complete implementation (Ray and Masuka, 2017). The economic and political dynamics in Zimbabwe significantly influence the extent and quality of healthcare delivery (Mangundu, Roets, and Janse van Rensberg, 2020). The country operates a four-tier healthcare system, ranging from rural hospitals to central hospitals in major cities, however, broader economic challenges have impacted the availability of essential medical drugs, particularly in rural health facilities (Chilunjika and Muzvidziwa-Chilunjika, 2021). It is noteworthy that only 20% of rural health facilities in Zimbabwe possessed essential drugs for treating common chronic diseases (Mangundu, Roets, and Janse van Rensberg, 2020), indicating a significant gap in health service provision.

The spatial distribution of health facilities poses challenges to accessibility in rural areas, where individuals may need to traverse substantial distances to reach the nearest health facility (Chilunjika and Muzvidziwa-Chilunjika, 2021). Poor infrastructure, exemplified by unmaintained roads, exacerbates these accessibility issues. Additionally, Zimbabwe's failure to meet the minimum 15% annual health budget allocation, as outlined in the Abuja Declaration of 2001, has repercussions for resource availability in the health sector (Chilunjika and Muzvidziwa-Chilunjika, 2021).

The identified literature gap pertains to the limited exploration of the persistent challenges hindering the full implementation of Primary Health Care (PHC) in Zimbabwe, despite the country's initiation of the PHC program in 1982. While there is acknowledgment of the transformative impact of the

Alma-Ata Declaration and the subsequent efforts to enhance rural healthcare infrastructure, extend immunisation initiatives, and address various health concerns, there is a lack of in-depth analysis regarding the sustained obstacles faced by Zimbabwe's health sector.

Specifically, the literature does not extensively delve into the ongoing impediments, such as skills migration, insufficient investment, and resource constraints that have hindered the comprehensive implementation of the PHC approach. Additionally, the economic and political dynamics in Zimbabwe, highlighted as influential factors, need further exploration to understand their nuanced impact on the extent and quality of healthcare delivery.

This research delves into the diverse difficulties encountered by rural communities in Zimbabwe when accessing healthcare services. The primary aim of the study was to examine the patterns and factors influencing health trends in rural areas of Zimbabwe, utilizing data derived from the Zimbabwe Demographic Health Surveys conducted from 1999 to 2016.

METHODOLOGY

This research utilised data from five consecutive Zimbabwe Demographic and Health Surveys (ZDHS), conducted in 1999, 2005/6, 2010/11 and 2016. In these surveys, the data were collected with a nationally representative sample of women and men of reproductive age. Key informant interviews (KII) were conducted in Mashonaland Central province. This province was purposively selected because of its proximity to the researcher. Key informant interviews (KIIs) were carried out, employing a guide specifically designed for key informants, with participants including members of the Mashonaland Central Provincial Health Executive and health centre Sister-in-Charge. These interviews aimed to gather service provider-level insights into the challenges confronting the broader rural population in Zimbabwe. Through the KIIs, essential information was obtained, shedding light on the factors influencing health-seeking behaviours. Participants in these interviews played a crucial role in delivering key insights and providing valuable information that contributes to a comprehensive understanding of the complexities surrounding healthcare in rural Zimbabwe.

RESULTS

CONTRACEPTIVE USE

The overall prevalence of contraceptive use in Zimbabwe is relatively high, standing at 66. It is pertinent to highlight a noteworthy distinction between rural and urban areas, where contraceptive usage differs. In rural settings, the

contraceptive usage rate is slightly lower, at 63%, compared to the higher rate observed in urban areas, which stands at 71%. A significant trend emerges when examining the historical data. Over the years, there has been a consistent and notable increase in contraceptive use in rural areas. In 1999, the contraceptive usage rate in rural areas was 44%, and this has steadily risen to 63% by 2016. Conversely, in urban areas, the increase has also been substantial, with contraceptive use rising from 62% in 1999 to a current rate of 71%. These trends suggest an overall positive trajectory in contraceptive adoption, reflecting changing patterns and attitudes toward family planning practices in both rural and urban contexts.

Table 1: *Percentage distribution of contraception by socio-economic variables*

Year	**1999**	**2005**	**2010**	**2015**
Urban	61.8	68.3	60.4	70.7
Rural	43.9	53.4	55.7	63.2
Total	**50.4**	**58.4**	**57.3**	**65.8**

The lag in contraceptive use in rural areas was explained by a sister-in-charge of one clinic who in a key informant interview shared the following remarks:

> *In all honesty, our educational efforts encompass the teaching and provision of diverse contraceptive methods. Nevertheless, it is crucial to acknowledge that many individuals hold strong religious beliefs that prohibit them from utilizing contraception. Despite our comprehensive education on modern contraceptive options, some individuals adhere to traditional methods due to the influence of their religious convictions. This underscores the complex interplay between cultural, religious, and personal beliefs that impact individuals' choices regarding family planning and contraception. In our efforts, we respect and navigate these diverse perspectives to ensure that our educational programs are sensitive to the cultural and religious backgrounds of the communities we serve.*

The statement was buttressed by a member of the Mashonaland Central Provincial Health Executive, who expressed the following viewpoint:

> The influence of traditional religious beliefs, especially within the Apostolic sector, plays a pivotal role in shaping the healthcare-seeking behaviours of the local population. Adherents often adhere to traditional healing practices and may harbour reservations or apprehensions toward modern medical interventions, including the use of contraceptives. The cultural and religious dynamics create a distinct challenge for public health initiatives aimed at promoting family planning and contraception. Addressing this issue requires a nuanced and culturally sensitive approach that involves engaging with local traditional leaders, religious figures, and community members. Collaborative efforts between healthcare providers and traditional influencers are essential to bridge the gap between traditional beliefs and the promotion of modern healthcare practices, including the adoption of

> contraception in rural areas. This approach should prioritize mutual understanding, respect for cultural diversity, and the integration of traditional and modern healthcare perspectives. In our province, we have a significant presence of traditional churches, particularly from the Apostolic sector, where adherents are often discouraged from seeking conventional healthcare. This factor contributes to the observed low adoption of contraception in many of our rural areas.

HIV TESTING

The overall prevalence of HIV testing in Zimbabwe is relatively low, standing at 36%. It is crucial to highlight a notable disparity between rural and urban areas, where HIV testing rates differ. In rural settings, the HIV testing rate is slightly lower, at 35%, compared to the higher rate observed in urban areas, which stands at 38%. Examining historical data reveals a noteworthy and positive trend in HIV testing rates. Over the years, there has been a consistent and substantial increase in HIV testing in rural areas. In 1999, the HIV testing rate in rural areas was only 6%, and this has progressively risen to 35% by 2016. Similarly, in urban areas, there has been a significant increase, with HIV testing rates rising from 13% in 1999 to the current rate of 38%. These trends indicate a positive shift in attitudes and behaviours related to HIV testing, reflecting an increased awareness and understanding of the importance of regular testing in both rural and urban contexts. Despite the improvements, efforts to further enhance HIV testing rates, especially in rural areas, remain crucial for comprehensive public health interventions and disease management**.**

Table 3: *Percentage distribution of HIV Testing by socio-economic variables*

Year	**1999**	**2005**	**2010**	**2015**
Urban	13.1	10.3	22.1	37.9
Rural	6.3	4.2	19.5	34.7
Total	9.2	6.6	20.4	35.9

The lag in HIV testing in rural areas was explained by a sister-in-charge of a clinic, who, during a key informant interview, shared the following remarks:

> Despite the relatively low levels of HIV testing in comparison to urban areas, there has been a noticeable improvement over the years. It's worth noting that residents in these rural areas often have to traverse considerable distances to access these services. While the current utilization levels may not meet our desired targets, there is a positive trajectory, and we are making progress in enhancing accessibility and usage of these crucial services.

This was supported by the Mashonaland Central Provincial Health Executive who made the following remark:

> The Ministry has achieved significant milestones in HIV testing across the province, encompassing both urban and rural areas. The reception and utilization of HIV testing services have been commendable thus far. Our overarching goal aligns with the National Development Strategy 1, aiming to ensure that every individual has access to these essential services. Despite persistent challenges related to long distances, we are actively addressing this issue through innovative approaches such as mobile clinics and outreach programs. These initiatives are specifically designed to reach remote and hard-to-access areas, ensuring that healthcare services, including HIV testing, are extended to every corner of the province.

HIV PREVALENCE

The overall prevalence of HIV in Zimbabwe is relatively high, standing at 14%. It is important to note a significant gender-based disparity, with higher HIV prevalence among women at 17% compared to men at 11%. Delving into the demographic specifics, HIV prevalence trends show interesting patterns. Among women, there has been a consistent decrease in HIV prevalence in both rural and urban areas. In rural areas, the prevalence among women declined from 21% in 2005 to 17% in 2016, mirroring a similar trend in urban areas. Among men, there is also a positive trajectory with consistent decreases in HIV prevalence. In rural areas, HIV prevalence among men decreased from 14% in 2005 to 10% in 2016. In urban areas, a similar decline is observed, with prevalence decreasing from 16% in 2005 to 11% in 2016. These trends indicate progress in HIV prevention and awareness efforts, particularly in reducing the prevalence rates among both women and men in both rural and urban contexts. Continued efforts in public health interventions, education, and access to healthcare services are essential to sustain and further improve these positive trends in HIV prevalence reduction.

Table 4: *Percentage distribution of HIV Prevalence by socio-economic variables*

	HIV Prevalence Women				**HIV Prevalence Men**			
Year	**1999**	**2005**	**2010**	**2015**	1999	2005	2010	2015
Urban	not available	21.6	19.6	16.8		15.7	13.1	11.3
Rural		20.8	16.8	16.6		13.8	12	10.1
Total		**21.1**	**17.7**	**16.7**		**14.5**	**12.7**	**11.3**

HIV prevalence is lower in rural areas compared to urban areas. One of Mashonaland Central Provincial Health Executive who made the following remark:

> In our province, we have undertaken the implementation of comprehensive sexuality education across all health centres. This initiative goes beyond just educating individuals; it includes comprehensive teachings on safe sexual practices and the provision of both male and female condoms. Additionally, various organisations, including churches, the private sector, and NGOs, are actively involved in implementing HIV&AIDS projects within the province. The collaborative efforts of these diverse stakeholders are geared towards maintaining a low HIV prevalence rate in our community. Through these concerted endeavours, we aim to empower individuals with knowledge and resources to make informed decisions about their sexual health, thereby contributing to the overall well-being of the population.

This was supported by a sister-in-charge of one clinic who in a key informant interview shared these remarks:

> As part of our regular practice, we engage in educating our clients on matters related to sexuality, placing particular emphasis on safe sex practices. Furthermore, we actively distribute condoms to our clients, promoting the adoption of preventive measures to ensure their sexual health and well-being. This routine approach reflects our commitment to empowering individuals with essential knowledge and resources, fostering a culture of responsibility and informed decision-making in the realm of sexual health.

SEXUAL VIOLENCE

The overall prevalence of sexual violence in Zimbabwe is relatively high, standing at 14%. It is pertinent to highlight a notable distinction between rural and urban areas, where sexual violence rates differ. In rural settings, the prevalence of sexual violence is higher, at 14%, compared to the slightly lower rate observed in urban areas, which stands at 13%. Examining historical data reveals a noteworthy and positive trend in the prevalence of sexual violence. Over the years, there has been a consistent and substantial decrease in sexual violence in both rural and urban areas. In rural areas, the prevalence of sexual violence has halved, declining from 28% in 2005 to 14% in 2016. Similarly, in urban areas, there has been a significant decrease, with the prevalence of sexual violence dropping from 21% in 2005 to 13% in 2016.

These encouraging trends suggest progress in efforts to address and combat sexual violence in Zimbabwe. The consistent reduction in prevalence rates, particularly in rural areas where the rates were initially higher, indicates positive shifts in societal attitudes, awareness, and possibly improvements in prevention and intervention measures. Continued commitment to comprehensive strategies for addressing sexual violence is crucial to maintaining and furthering these positive trends.

Table 5: *Percentage distribution of Sexual violence by socio-economic variables*

Year	1999	2005	2010	2015
Urban	not available	20.8	28.0	13.1
Rural		27.8	26.7	13.8
Total		**25.0**	**27.2**	**13.5**

Whilst the levels of sexual violence in rural areas is higher than in urban areas, there has been a significant decrease in sexual violence cases in the province as explained by a sister-in-charge of a clinic, who, during a key informant interview, shared the following remarks:

> Our collaborative efforts extend to partnering with various stakeholders, including law enforcement agencies such as the police, to conduct extensive community awareness campaigns on the perils of sexual violence. These initiatives have proven instrumental in diminishing the prevalence of sexual violence cases within our community. Although instances of such incidents persist, the notable progress witnessed underscores the positive impact of our collective endeavours in addressing and mitigating this pressing issue. Through these collaborative initiatives, we aim to foster a heightened awareness of the consequences and implications of sexual violence, encouraging a community-wide commitment to preventing and responding to such incidents. The involvement of law enforcement adds an additional layer of deterrence, emphasizing the legal consequences perpetrators may face. While challenges remain, the ongoing collaboration and awareness-building efforts contribute to creating a safer and more informed community environment.

This was supported by One of Mashonaland Central Provincial Health Executive who made the following remark:

> Our proactive collaboration involves working closely with stakeholders from other sister ministries to intensify awareness campaigns addressing sexual violence. This robust partnership has played a pivotal role in achieving a gradual reduction in the levels of sexual violence over the years. While it may be premature to declare an outright victory in the fight against sexual violence, the encouraging progress we've observed underscores the effectiveness of our joint efforts. This collaborative approach extends the reach and impact of our awareness initiatives, leveraging the resources and expertise of multiple ministries. By fostering a comprehensive and coordinated response, we aim to address the root causes of sexual violence and promote a culture of prevention and support within our community. Ongoing efforts focus on sustaining this positive trajectory, recognizing that continuous collaboration and awareness are essential components in the ongoing battle against sexual violence.

PHYSICAL VIOLENCE

The overall prevalence of physical violence in Zimbabwe is relatively high, standing at 35%. It is important to highlight a notable distinction between

rural and urban areas, where physical violence rates differ. In rural settings, the prevalence of physical violence is higher, at 35%, compared to the slightly lower rate observed in urban areas, which stands at 34%. Examining historical data reveals a nuanced trend in the prevalence of physical violence. Over the years, there has been a consistent and moderate decrease in physical violence in rural areas. From 2005 to 2016, the prevalence of physical violence in rural areas declined from 39% to 35%, indicating a positive shift in societal dynamics. Conversely, in urban areas, there was a slight increase in physical violence, rising from 32% in 2005 to 34% in 2016. These trends suggest a mixed picture regarding the prevalence of physical violence in Zimbabwe. While there has been progress in reducing physical violence, particularly in rural areas, the slight increase in urban areas indicates the need for targeted interventions and continued efforts to address this issue comprehensively. Continued commitment to awareness, education, and community-based programs can contribute to sustaining the positive trend and mitigating the challenges associated with physical violence.

Table 6: *Percentage distribution of Physical Violence by socio-economic variables*

Year	**1999**	**2005**	**2010**	**2015**
Urban	not available	31.7	28.9	34.2
Rural		39.1	30.5	35.2
Total		**36.2**	**29.9**	**34.8**

While the levels of physical violence in rural areas are higher than in urban areas, there has been a slight decrease in physical violence cases in the province, as explained by a sister-in-charge of a clinic, who, during a key informant interview, shared the following remarks:

> The statistical data highlights that high levels of physical violence persist, albeit with slight decreases over the years. This underscores the urgent need to amplify awareness campaigns, engaging key stakeholders such as traditional and religious leaders. The involvement of these influential figures is crucial in the ministry's concerted efforts to effectively address and reduce instances of physical violence within our communities.
>
> To tackle this persistent challenge, a comprehensive strategy is essential, and the collaboration with traditional and religious leaders adds a valuable dimension. By enlisting their support, we aim to enhance the impact of awareness initiatives, leveraging their influence to foster behavioural change and community-wide understanding. The statistical trends indicate the importance of sustained efforts, and through these collaborations, we endeavour to create a safer and more secure environment for all.

This was supported by One of Mashonaland Central Provincial Health Executive who made the following remark:

> The ministry collaborates with religious and traditional leaders in the province to promote peace within communities. Despite consistent efforts, the levels of physical violence have remained largely unchanged, and there are even signs of an increase in certain areas. Ongoing engagements with community leaders persist to ensure a sustained focus on fostering peace and addressing the challenges contributing to violence in our communities.

MALNUTRITION IN CHILDREN

The overall prevalence of malnutrition in children in Zimbabwe has remained constant at 27% from 1999 to 2016. It's important to highlight a significant distinction between rural and urban areas, where malnutrition rates in children differ. In rural settings, the prevalence of malnutrition in children is higher, at 29%, compared to the lower rate observed in urban areas, which stands at 22%. Examining historical data reveals a notable and concerning trend in the prevalence of malnutrition in children. In rural areas, malnutrition rates have remained consistent at 29% from 1999 to 2016, indicating a persistent challenge in addressing nutritional needs in these regions. Conversely, in urban areas, there has been a slight increase in malnutrition rates, rising from 21% in 2005 to 22% in 2016. These trends underscore the importance of targeted interventions and nutritional programs, particularly in rural areas, to address and mitigate the high prevalence of malnutrition in children. The increase observed in urban areas also signals the need for ongoing efforts to ensure access to nutritious food and healthcare services for children in both rural and urban contexts. Sustainable and comprehensive strategies are crucial to addressing malnutrition and promoting the well-being of children across Zimbabwe. The overall levels of malnutrition in children remained constant at 27% from 1999 to 2016. Worth noting is the fact that malnutrition in children in rural areas is higher, 29% compared to urban areas, 22%. Malnutrition in children have remained consistent in rural areas at 29% between 1999 to 2016, while it increased in urban areas from 21% in 2005 to 22% in 2016.

Table 7: *Percentage distribution of Malnutrition in children by socio-economic variables*

Year	**1999**	**2005**	**2010**	**2015**
Urban	20.6	23.8	27.5	22.1
Rural	29.2	31.2	33.4	28.5
Total	**26.5**	**29.4**	**32.0**	**26.8**

While the levels of malnutrition in rural areas are higher than in urban areas, there has been a slight increase in urban areas, as explained by a sister-in-charge of a clinic, who, during a key informant interview, shared the following remarks:

> Over the past decade, the levels of malnutrition experienced an increase due to the economic challenges faced by the country. However, there is a positive shift in recent times, signalling an encouraging trend of declining malnutrition rates. This improvement underscores the intensity of efforts implemented to address malnutrition effectively. Non-governmental organisations (NGOs) play a pivotal role in spearheading initiatives to combat hunger in the province, marking a welcomed and collaborative development. The concerted efforts from various stakeholders reflect a collective commitment to alleviate malnutrition and enhance the overall well-being of the population in the face of economic adversities.

This was supported by One of Mashonaland Central Provincial Health Executive who made the following remark:

> *The government is actively engaged in comprehensive initiatives aimed at* eradicating hunger and addressing malnutrition, evident in the National Development Strategy 1, which includes a dedicated pillar focused on ending poverty. This strategic approach underscores the commitment to ensuring food security and improved nutrition for the population. Notably, there has been a collaborative effort involving various partnerships, with private entities joining hands to complement government endeavours. The commendable involvement of private players enhances the breadth and depth of interventions, contributing to a more effective and sustainable impact. As the province is recognized as the breadbasket of the nation, on-going efforts persist to provide ample food resources not only for its residents but also extending support beyond its borders.

VACCINATION OF CHILDREN

The overall levels of children's vaccination in Zimbabwe are high and continue to increase, currently standing at 76%. However, it's essential to highlight a notable distinction between rural and urban areas, where vaccination rates for children differ. In rural settings, the vaccination rate is slightly lower, at 75%, compared to the higher rate observed in urban areas, which stands at 81%. Examining historical data reveals an interesting trend in children's vaccination rates. In rural areas, vaccination rates have shown fluctuation, starting at 72% in 1999, decreasing to 50% in 2005, and then experiencing a substantial increase to 75% in 2016. This indicates a positive rebound in vaccination efforts in rural regions. Conversely, in urban areas, there was an initial high vaccination rate of 81% in 1999, followed by a decrease to 58% in 2005. However, there has been a subsequent increase, reaching 81% in 2016. These trends suggest the overall success and effectiveness of vaccination programs in Zimbabwe, with concerted efforts leading to increased vaccination coverage. While rural areas have witnessed significant improvements, on-going strategies are essential to further bridge

the gap between rural and urban vaccination rates. Continued advocacy, accessibility, and education on the importance of vaccination remain crucial to sustaining and enhancing these positive trends for the overall health and well-being of children in Zimbabwe.

Table 8: *Percentage distribution of Vaccination of children by socio-economic variables*

Year	**1999**	**2005**	**2010**	**2015**
Urban	81.3	58.00	69.9	80.5
Rural	71.7	50.2	62.3	74.5
Total	**74.8**	**52.6**	**64.5**	**76.0**

While the levels of Vaccination in rural areas are lower than in urban areas, there has been a considerable increase in rural areas, as explained by a sister-in-charge of a clinic, who, during a key informant interview, shared the following remarks:

> Despite facing shortages in the past decade, there has been a positive resurgence in child vaccination, thanks to the concerted efforts of extensive awareness campaigns. Parents are now actively bringing their children for vaccination, marking a notable turnaround. This success is attributed to collaborative initiatives involving traditional and religious leaders who play pivotal roles in facilitating and encouraging vaccination efforts. Additionally, strong partnerships with Village Health Workers and Child Care Workers have been forged, ensuring that vaccination outreach extends to every corner of the communities. The collaborative approach and community engagement underscore the commitment to achieving widespread immunisation coverage and safeguarding the health of children across the region.

This was supported by One of Mashonaland Central Provincial Health Executive who gave the following insight:

> Significant strides have been made to enhance vaccination efforts since the country gained independence. These initiatives align with the principles of the primary health care approach, emphasizing accessibility and inclusivity. Traditional and religious leaders play crucial roles as stakeholders, collaborating closely with the ministry to boost child vaccination rates. Despite challenges posed by economic hardships and natural disasters in the past decades, recent increases in vaccination rates reflect deliberate government efforts. The commitment to achieving universal coverage, particularly in rural areas, underscores the government's dedication to the mantra of "leaving no one and no place behind." Ongoing collaboration and targeted interventions are pivotal for sustaining and expanding these positive trends in vaccination coverage.

DISCUSSION

The prevalence of contraceptive use in Zimbabwe is commendably high at 66%, with a positive trend observed in both rural and urban areas. Urban areas boast a higher rate of 71%, compared to rural areas at 63%. Notably, a

consistent increase has been witnessed from 44% in rural areas and 62% in urban areas in 1999 to the current rates in 2016. These trends suggest a positive shift in attitudes towards family planning, indicating changing perspectives in both rural and urban settings. HIV testing rates in Zimbabwe, though relatively low at 36%, display an encouraging upward trajectory. Rural areas, with a rate of 35%, have seen a considerable increase from 6% in 1999. Urban areas also exhibit positive growth, rising from 13% in 1999 to 38% in 2016. These trends signify increased awareness and understanding of the importance of regular HIV testing, emphasizing the need for sustained efforts to further enhance testing rates.

HIV prevalence in Zimbabwe is notable at 14%, with a gender-based disparity of 17% among women and 11% among men. Encouragingly, there is a consistent decrease in HIV prevalence among both women and men in rural and urban areas, indicating progress in prevention and awareness efforts. Continued commitment to public health interventions, education, and accessible healthcare services is crucial for sustaining these positive trends. Sexual violence prevalence in Zimbabwe stands at 14%, with a higher rate in rural areas (14%) compared to urban areas (13%). Despite the overall high prevalence, there has been a significant decrease from 28% in rural areas and 21% in urban areas in 2005. These trends indicate positive shifts in societal attitudes, awareness, and interventions against sexual violence. The prevalence of physical violence is relatively high at 35%, with a higher rate in rural areas (35%) compared to urban areas (34%). While rural areas show a consistent decrease from 39% in 2005, urban areas witnessed a slight increase from 32% to 34% in 2016. This mixed picture underscores the need for targeted interventions and continued efforts to comprehensively address physical violence.

Malnutrition in children has remained constant at 27% from 1999 to 2016, with a higher prevalence in rural areas (29%) compared to urban areas (22%). This persistent challenge in rural areas emphasizes the necessity for targeted nutritional programs and interventions to address the nutritional needs of children. Children's vaccination rates are high at 76%, with rural areas slightly lower at 75% compared to urban areas at 81%. The fluctuation in rural vaccination rates, decreasing to 50% in 2005 and rebounding to 75% in 2016, calls for sustained efforts to bridge the gap between rural and urban vaccination rates.

CONCLUSION

The positive trends in contraceptive use, HIV testing, and prevalence, as well as the decrease in sexual violence, highlight progress in Zimbabwe's public health landscape and the steady provision and realisation of women’s sexual

and reproductive rights. However, challenges like physical violence and persistent malnutrition in rural areas require ongoing attention and targeted interventions for a holistic improvement in health indicators across the country. The study concludes that rural populations are experiencing more challenges than their urban counterparts. Failure to address these challenges could impede Zimbabwe from attaining the Sustainable Development Goals (SDGs) established by the United Nations in 2015, similar to the difficulties faced in achieving the Millennium Development Goals. The study recommends that Zimbabwe should strive to allocate 15% of the total fiscal budget to the health sector to enhance the likelihood of success in achieving the SDGs. This financial commitment is deemed crucial for overcoming the existing healthcare disparities between rural and urban areas, ultimately contributing to the nation's progress toward meeting international development goals.

REFERENCES

Bronfenbrenner, U. (1979). Contexts of Child Rearing: Problems and Prospects. *American Psychologist, 34*(10), 844.

Chilunjika-Muzvidziwa, S. R. and Chilunjika, A. (2021). Dynamics Surrounding the Implementation of the Primary Health Care Approach in Zimbabwe's Rural Areas: The Case of Mt Darwin District.

Mangundu, M., Roets, L. and Janse Van Rensberg, E. (2020). Accessibility of Healthcare in Rural Zimbabwe: The Perspective of Nurses and Healthcare Users. *Afr J Prm Health Care Fam Med., 12*(1), a2245.

Rifkin, S. B. (2018). Alma Ata after 40 Years: Primary Health Care and Health For All—From Consensus to Complexity. *BMJ Global Health, 3*(Suppl 3).

Ray, S. C. and Masuka, N. (2017). Facilitators and Barriers to Effective Primary Health Care in Zimbabwe. *African Journal of Primary Health Care & Family Medicine, 9*(1), 1-2.

United Nations, Department of Economic and Social Affairs (UNDESA), Population Division. (2015). World Urbanization Prospects: The 2014 Revision. New York, UNDESA.

World Bank. (2018). Poverty and Shared Prosperity 2018: Piecing Together the Poverty Puzzle. World Bank, Washington, D.C. World Bank.