

Unpacking Zimbabwe's Sub-national Health Systems Governance Dynamics in the 21st Century: A Scoping Review

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Abstract *Health system governance is growing in prominence globally, with increasing recognition of its role in health system performance, particularly in low- and middle-income countries. Zimbabwe's Ministry of Health and Child Care (MOHCC) emphasizes the criticality of effective health governance for equitable and universal health coverage. However, despite the efforts, governance challenges persist, and the subject remains under-explored in Zimbabwe. This scoping review systematically maps and synthesizes evidence on subnational health system governance in Zimbabwe in the 21st century. Databases searched include PubMed Central, Science Direct, Springer Nature Link, ProQuest, Google Scholar, and grey literature. Based on the employed search criteria, ten studies were identified and included in the review. The review found persistent governance challenges across governance domains, across governance levels and throughout the period under review. Poor accountability, weak leadership capacity, inadequate decision-space, undervalued community governance structures were frequently cited. Few studies demonstrated potential for enhancing health governance through deliberate efforts to capacitate governance structures and systematically institutionalize governance in the wider health functions. The review found that evidence on subnational health governance in Zimbabwe was scant. Strengthening the evidence base on subnational health governance through empirical research will be essential for informing future health sector reforms that strengthen governance at the subnational level.*

Keywords *Decision-Space, Governance Domains, Health Governance, Leadership, Subnational.*

Introduction

Governance has emerged as a central theme in public health discourse and is increasingly recognized as a key driver for sustainable public health. The World Health Organization (WHO) defines health systems governance as processes that involve setting strategic direction, formulating policy, enforcing accountability, and overseeing system performance [1]. In decentralized systems, governance functions are distributed across multiple levels, making subnational governance particularly influential in shaping service delivery outcomes because it is responsible for frontline service provision. Understanding the governance dynamics at subnational levels is therefore essential for identifying pathways for health governance reform.

Zimbabwe's health system evolved through early post-independence expansion and decentralization. However, reform efforts have been affected by challenges including recurring public health emergencies, economic decline, socio-political challenges, and staff attrition, among others [2].

This scoping review maps and synthesizes existing evidence on sub-national health systems governance in Zimbabwe in the 21st century. Specifically, it examines how governance is structured, how it functions, how external factors influence it, and its role in shaping health sector performance.

Literature Review

Conceptual Foundations of Health System Governance

The WHO identifies health system governance as one of the six health systems building blocks, alongside service delivery, health workforce, information systems, medical products, and financing. Different health system governance dimensions or domains have been proposed, including leadership and stewardship; accountability, transparency; participation, inclusiveness, and equity;

decentralization and decision space; coordination; and information and learning [3]. Effectively applying these governance dimensions in the health system is critical to achieving a nation's health goals. The realization of these health goals, especially across low- and middle-income countries (LMIC), is often undermined by persistent systemic challenges that constrain not only health service delivery, but also health governance itself.

Health Governance Dynamics: Global and Regional Perspective

Global efforts toward Universal Health Coverage emphasize equity and accountability. Developed countries have all-encompassing, higher-performing multi-level governance frameworks [4], while LMICs continue to face systemic governance challenges, including uneven decentralization, opaque resource allocation, and fragmented accountability [5]. In Africa, for example, the role of strong health governance in enhancing equitable access to health is documented [6], with regional bodies such as the African Union (AU) increasingly emphasizing the importance of governance in health, in particular multi-level and subnational governance as instrumental to ensure effective implementation of national and continental health strategies [7].

Lessons from LMIC countries show that strong, broad vision; clear strategic direction; local leadership capacity; clear mandates; and adequate resources are essential to effective health governance [8]. The implementation of different strategies to strengthen local governance through decentralized decision making, community participation, performance monitoring and financial governance have shown promising results across different African countries, although more sustained efforts will be needed to ensure these strategies are implemented at scale for long-term system-wide impact [9].

Health Governance Dynamics: Zimbabwe's Perspective

Zimbabwe has a multi-level health system governance structure managed from the national level by the Ministry of Health and Child Care (MOHCC), to the provincial health executives (PHEs), district health executives (DHEs), and facility-level health centre committees (HCCs). These structures are mandated to coordinate policy and planning, resource mobilization, accountability, service delivery among others. The MOHCC's National Health Strategy of 2021–2025, prioritizes effective governance among other strategies to realize its goals towards health for all [10]. However, MOHCC's governance efforts have been constrained across levels by challenges such as inadequate decentralization, weak regulatory frameworks, inadequate staffing, weak leadership capacity, and limited resources [11].

Evidence suggests that Zimbabwe continues to reform its health governance structures, however, sub-national health governance dynamics remain underexplored. Most studies focus on financing, human resources, or national-level reforms, with limited attention to how provincial, district, and facility-level governance structures function and interact. This scoping review addresses this gap by mapping and synthesizing evidence on governance dynamics at sub-national levels, highlighting successes, challenges and opportunities.

Methodology

Study Design

This study utilised a scoping review design, a suitable choice of study design considering the subject covered by the research topic is not well developed, still emerging and is underexplored in Zimbabwe. This is unlike systematic literature reviews which provide a narrowly focused synthesis from a well-developed topic [12]. The scoping review

design follows a systematic approach for identifying and analyzing existing evidence on sub-national health system governance dynamics in Zimbabwe.

This scoping review was conducted following the recommended 5 stages of scoping review from identifying to summarizing and reporting the results [13]. The PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) checklist was also utilised to systematically document the search and screening process, and consistent with scoping review methodology, it focused on mapping available evidence without assessing study quality [14].

Research Questions

What evidence exists on health governance dynamics within sub-national health systems in Zimbabwe within the 21st century?

Sub-questions included:

1. What are the structures and mechanisms of health governance at subnational level?
2. What is the performance of the subnational governance across governance domains?
3. What are the enablers and barriers to health governance at subnational level?

Search Strategy

A comprehensive search strategy was developed to capture peer-reviewed articles, policy documents, and grey literature published between 2000 and 2026. The systematic literature search was conducted by MC (author) and EN as second reviewer (duly acknowledged in acknowledgements section) to minimise bias.

Databases

The databases searched include PubMed Central, Science Direct, Springer Nature Link, ProQuest, Google Scholar, and grey literature was sourced from Government Website, (mainly the MOHCC) and International Organizations' websites (WHO, UNICEF, World Bank).

Search Guide and Keywords

The search strategy used for articles is shown in Table 1, and key words were applied using different combinations across all databases.

Table 1. Database Search Guide

	Governance Focus	Geography
"Health" OR	"governance" OR	"Zimbabwe" OR
"Health System" OR	"Stewardship" OR	"sub-national" OR
"Health Sector"	"system governance" OR	"provinc*" OR
	"system stewardship" OR	"district" OR
	"decentraliz*" OR	"facility" OR
AND	"devolution"; OR	"hospital" OR
	"accountability" OR	"clinic" OR
	"transparency" OR	"health centre"
	"function*" OR	
	"perform*"	
	AND	

Inclusion Criteria

This scoping review included the studies which focused on Zimbabwe's health system governance at sub-national levels and addressed governance structures, their function and performance across different health governance domains and factors determining their performance. The studies included were primarily peer-reviewed articles but also included credible grey literature. All literature would have been published from 2000 to 2026.

Exclusion Criteria

The scoping review excluded studies which did not analyze governance issues, even though they may have mentioned governance, such as where governance is not the focus of the article, publications that only focused on national-level governance without including sub-national health governance, non-English publications and those outside the timeframe.

Study Selection

The selection process for the studies followed the PRISMA-ScR guidelines. The titles and abstracts for all articles that were returned from the initial search were screened.

Full-text screening was conducted for articles meeting inclusion criteria. This full screening was conducted independently by MC and EN, and the selection of the articles for final inclusion was done by both on consensus. A flow diagram was used to document the screening and selection process.

Data Extraction

A standardized data extraction form was developed in Excel and the relevant information from included studies was captured to include the author/s, publication year, title, study design, aim, target population and the key findings.

Overview of Included Studies

This scoping review included a total of 10 publications in the final analysis. These publications explicitly addressed sub-national health governance in Zimbabwe, examining the governance structures and processes at provincial, district and facility levels. The studies comprised empirical research articles, case studies, and policy analyses, spanning the period from 2000 to 2026. The included articles were heterogeneous, with different designs, scope, governance levels and context.

Evidence Synthesis of Included Articles

Considering the heterogeneity of the studies included, narrative synthesis method was applied for analyzing and summarizing the findings from the included studies [15]. Thematic synthesis was employed to identify emerging themes across articles. The themes were aligned as much as possible with - but not limited to - the WHO health governance dimensions. This was necessary so that evidence dictates the themes and not vice versa.

Ethical Considerations

This study utilizes published literature and does not involve human participants; hence ethical approval is not required. However, relevant ethical principles such as acknowledgment of sources and accuracy were consistently upheld.

Study Limitations

The included articles were methodologically heterogenous; hence the findings and conclusions need to be interpreted with this mind. The review only searched published sources, hence automatically excludes any

unpublished reports which could potentially enrich the evidence. While clearly the small literature base which is too few for the 26 years considered under this review is a notable limitation for making meaningful conclusions for Zimbabwe's national landscape, it is also a clear justification for the appropriateness of a scoping review design for this study. Other potential limitations for this scoping review include language restriction to English and restrictions to Zimbabwean context which limits generalizability beyond Zimbabwe.

Results

Search Results

A total of 3,511 records were retrieved from the systematic search. Following de-duplication and application of exclusion criteria, 86 articles were retained for abstract screening and 46 selected for full-text review. After detailed review based on the inclusion criteria, a total of 10 publications were deemed eligible and included in the final synthesis. The figure 1 below shows the PRISMA ScR Flow Diagram which provides a summary of the search results.

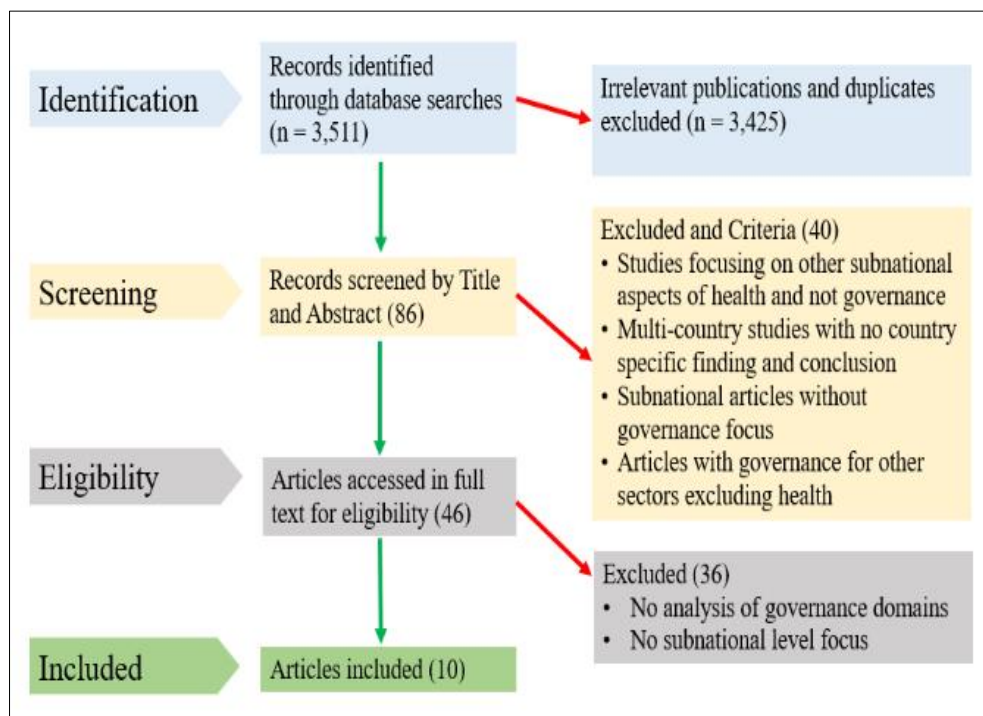


Figure 1. The Process of Screening and Selecting Studies

Individual Sources of Evidence

Table 2 below provides a summary of all the publications included in the final analysis of this scoping review. The summary includes for each publication, information on the author/s, title of article, study design, study population and key governance domains studied.

Summary Characteristics of Included Studies

Overall, 10 studies were included in the scoping review, with considerable heterogeneity in study design, focus and scale. Methodologically the evidence base included

mixed methods cross-sectional descriptive studies (4), mixed-methods implementation or programme evaluation studies (2), qualitative case studies (1), literature or document reviews (2), and national mixed-methods health systems assessment (1). Most studies (8/10) reported empirical findings only at subnational levels, while three studies examined governance across both national and subnational levels. The primary study populations were health system actors at subnational levels, such as provincial and district health executives, programme managers, hospital management board members, frontline health workers, and HCC members.

Table 2. Individual Sources Included in the Review

Authors	Year	Title	Study Design	Study Population and Subnational Focus	Governance Dimensions
Funhiro, et al., [16]	2021	Standardization and strengthening the functionality of hospital management boards in central hospitals: Evidence of a developing economy	Mixed-method study design using the questionnaire and interviews	six central hospital management boards with each comprising seven non-executive and four executive board members	Leadership, Oversight, Transparency, Accountability, Planning
Muchekeza, et al., [17]	2012	District health executives in Midlands Province, Zimbabwe: are they performing as expected?	Descriptive cross-sectional study	District health services managers across 5 districts in Midlands Province (Gokwe South, Chirumanzu, Gweru, Shurugwi and Zvishavane).	Leadership, Coordination, Oversight, Accountability, Human Resources, Administration
Osika, et al., [18]	2010	Zimbabwe Health System Assessment 2010	Mixed-methods, rapid, integrated, cross-sectional national Health Systems Assessment (HSA) methodology	MOHCC headquarters officials, Provincial and district health managers, Hospital managers and clinical staff, Pharmacy and Laboratory personnel, Health information officers Donor Agency,	Stewardship, Decentralization, Authority, Accountability, Transparency, Equity, Health committees, community governance and participation

				Civil Society and faith-based organization	
Zhanda, and Chitongo [19]	2023	Devolution as a health governance paradigm amidst the COVID-19 pandemic in Zimbabwe: Convergences and divergences	literature review of published documents, press releases and reports aided by content analysis	Sub-national tiers of government, local-level health front-line institutions, and local communities	Decentralization and Decision -making autonomy (“decision space”), Accountability, Resource governance and, Coordination, Community participation.
Loewenson, et al., [20]	2004	Assessing the impact of HCCs on health system performance and health resource allocation	cross-sectional community surveys	Three districts Makoni, Gweru, Goromonzi), covering HCC and non-HCC wards including women, youth, the elderly, men in each ward, covering a total of 8 health facilities	Participatory governance, Accountability, decision-space, Oversight and performance, Resources Management
Maponga, et al., [21]	2022	Lessons learnt from implementing the Good Governance for Medicines Programme in Zimbabwe	Descriptive, qualitative implementation analysis / lessons-learnt study	Programme implementers and technical experts, Regulatory, procurement stakeholders at national and subnational levels in the MOHCC, Medicines Control Authority of Zimbabwe, National Pharmaceutical Services and Quality Assurance Units	Transparency, Accountability and oversight, capacity, decentralization, governance reforms

Witter et al., [22]	2019	The political economy of results-based financing: the experience of the health system in Zimbabwe	retrospective qualitative case study	National level and in two provinces (Mid-lands and Mashonaland East), including four districts (Murewa, Marondera, Gokwe North and Gokwe South).	Decision Making, Roles and multi-level relations, Ownership and Accountability
Chung et al., [23]	2020	Scaling up malaria elimination management and leadership: a pilot in three provinces in Zimbabwe, 2016-2018	Mixed-methods pilot implementation and programme evaluation	Provincial, District malaria programme managers; focal persons, Nurses, frontline malaria staff; health surveillance, case management, and vector control staff	Leadership skills and Management capacity, accountability and ownership, coordination (vertical and horizontal), decentralization
Kanonhuhwa [24]	2020	COVID-19 and the Environmental Hygiene Question: Some Proposals for Urban Health Governance in Zimbabwe	Case Study Literature Review	Urban cities within and outside Zimbabwe	Accountability, Resource mobilization, Community participation, social governance, coordination,
Taderera et al., [25]	2017	Human resource for health reform in peri-urban areas: a cross-sectional study of the impact of policy interventions on healthcare workers in Epworth, Zimbabwe	Cross-sectional study	Healthcare workers employed in health facilities located in Epworth, a peri-urban settlement near Harare, Zimbabwe.	Accountability, Stewardship, Human resource management and administrative governance, Policy implementation

Findings from Included Studies by Governance Domains

The most common governance domains across the included studies were accountability, appearing in (8/10) of the included articles, followed by leadership and management (6/10), coordination (6/10), decentralization and decision-space (5/10), community participation (5/10), and cross-cutting factors affecting governance such as human resource or administrative capacity (4/10).

Accountability

Accountability in health system governance means actors hold themselves responsible for their decisions and actions they take and will be answerable to the outcomes of those decisions and actions. Common accountability measures from included studies are; reporting, performance audits, and oversight activities such as supervision, among others. The findings from the review show that accountability is one of the most studied governance domains, featuring across the sources included in this

review. Notably, across most of these studies, accountability was found to be deficient. A common observation across both urban hospital management boards and rural District Health Executives (DHEs), was that both urban and rural governance structures performed inconsistently regardless of context [16-18]. Similarly, challenges of meeting reporting requirements were also common across rural and urban contexts. Further, multi-level reporting accountabilities, such as between district and province or health facility and community, were compromised during a crisis response to the COVID-19 pandemic. During this period, accountability functions became more centralized, with upwards reporting prioritised and downward reporting to the communities compromised [19].

Additional accountability deficits revealed from the review were that while most hospitals had hospital boards established, these boards lacked institutional guidance as they did not have clear policy framework to evaluate their performance. On the other hand, some DHEs were found to be failing to meet their deliverables for accountability such as conducting DHE meetings and documenting DHE minutes. Challenges such as inadequate training and staff capacity, resource constraints and unclear accountability guidelines were among the key factors attributed to accountability gaps.

At the community and local facility level, accountability was also a challenge. The review found that accountability to communities was better where HCCs existed, yet, they only existed in few facilities, and where they existed, they were either inadequately capacitated or resourced [20]. The poor accountability demonstrated by these findings is mainly driven by inadequate training, staff's lack of clarity regarding their leadership roles and unclear requirements on how they are to implement their accountability functions. However, it was found, from programme specific governance strategies, that there is potential of improving

accountability and enhancing oversight efforts [21].

Leadership and Stewardship

Leadership and stewardship is another domain that frequently featured in most of the included studies. For this review, leadership and stewardship refer to the institutional structures, their management function, as well as their role in translating policy into action at the subnational level.

Evidence from the included studies shows that while the Ministry's vision on health governance is clearly articulated in the National Health Strategy (2021–2025), this does not always translate into strong leadership across all subnational levels. Health leaders at both provincial and district levels were found to be not sufficiently knowledgeable about their roles, with majority confessing they did not have adequate management skills and capacity [17, 18]. Governance actors at these levels attributed some of these gaps to unavailability of institutional guiding frameworks which they could use as reference in delivering on their mandate. The review, however, noted how deliberate effort to create an enabling environment and capacitating subnational health leaders with formal governance policy documents and tools, systematic oversight activities, and leadership training could empower and guide subnational teams on their governance functions [16, 21].

This scoping review observed how leadership and stewardship roles of subnational structures can be hampered in contexts where there is resource competition. In Districts implementing the results-based financing (RBF) model, it was found that the leadership and management functions of district management teams or HCCs were compromised, as they fell under what was described as '*guided democracy*', where they were expected to follow instructions from superior offices or funding agencies [22]. This

meant that decision making would be influenced by resources and who controls them.

In spite of all these challenges, evidence from specific programme interventions found that targeted management and leadership support led to better leadership capacity, decision making, role clarity, sense of ownership and stronger health governance [23].

Transparency and Integrity

From the sources included in this review, transparency and integrity were among the key health governance domains that came up, although these were less pronounced than leadership or accountability. The review notes that transparency was widely regarded as an area of concern, with financial management or human resources issues often seen as opaque [16, 18, 22]. This had the effect of undermining trust and threatening unified efforts by subnational health governance bodies and ultimately affecting their overall performance. In unique ways, other included studies showed gaps in transparency as seen by fragmented urban health governance [24] and limited public access to information during emergency governance responses to COVID-19 [19]. In contrast, the ‘Good Governance for Medicines Programme’ provides an example of how integrity can be achieved when safeguards for transparency and integrity are deliberately integrated in routine systems [21]. At the interface of the health facility and local communities through HCCs, the evidence indicates that the presence of HCCs enhanced transparency in information sharing, which translated to improved decision-making and community participation [35].

Decentralization and Decision-Space

The concept of decentralization and decision-space refers to the efforts towards and the extent of delegation of authority and effectual decision-making power from central to subnational structures. Despite decentralization being an intrinsic factor of

Zimbabwe’s health system governance structure, evidence from this review shows that intention – as revealed by established MOHCC’s governance structures ‘on paper’ – has in practice, not always translated to full delegation of authority and actual decision-space for subnational structures [18, 22]. Notably, this ‘withholding’ of authority by superior structures is not consistent across the board, but more control is retained on matters considered of strategic importance such as policy decision-making, financing, and human resources. In this scenario, effective authority has not been fully ceded by superior offices but only given on a ‘piecemeal’ basis, making the concept of decentralization remain largely more rhetorical than practical and more discretion based than systematic. Furthermore, it was found that where subnational structures lack control of key issues such as financing or staffing, they are found to be largely weakened and sometimes demoralized [24, 25].

Another scenario from the evidence is that decentralized authority can be re-centralized, as observed during the COVID-19 pandemic where the MOHCC’s Headquarters led the pandemic response efforts by taking more control, directing how the response would be implemented across all levels of jurisdictions [19]. This limited the decision space of subnational teams with the effect of delaying response actions. At the community level, HCCs were present but not ubiquitous across all health facilities. Nonetheless, this is one structure where notable decision-space has been observed, despite some evident capacity and resource constraints [20]. However, the review also made some positive findings, where some studies demonstrated that autonomy at the provincial and district levels can be enhanced if the subnational structures are fully capacitated and allowed the decision-space to adapt strategies and tailor interventions according to their context [23].

Community Participation

The review found very few publications focusing on community participation as a health governance dimension. Unlike other governance domains which were observed from studies across different contexts and levels, the studies focusing on communication were primarily at the community level. The review found that health facilities with active HCCs managed to establish stronger collaboration and partnership between the service providers and service users in the community [20]. This strong engagement meant that communities were better informed about services available to them, and they were also engaged in planning, decision making and oversight of the health centre staff. Consequently, both the communities and health centre staff would become more responsive to each other's needs with a better sense of collective ownership. However, the study noted that the rollout of the HCC structure was uneven across provinces and districts and not adequately supported across all levels.

Cross-Cutting Governance Issues

In this review, cross-cutting governance issues are those underlying systemic conditions that apply across multiple governance domains and influence - both directly and indirectly - how governance functions are exercised across the domains. They are not in themselves governance domains. From the sources included in this review, some of the common cross-cutting issues that shaped subnational health governance include: the disconnect between formal governance arrangements and operational capacity, financing modalities, human resource constraints, inadequate staff capacity, underutilization of health information for decision making, and wider socio-political dynamics.

The review observed that centralized financing modalities are a major constraint which limits the flexibility of subnational structures to make decisions and prioritize

based on their local needs [18, 22]. It was also observed that innovative approaches such as the RBF or other programme specific financing strategies may introduce bias and distort the governance framework and accountability roles [22, 23]. For instance, dedicated investments through this approach were seen to have a tendency of 'forcing' performance, often due to incentives attached to them. As a result, health managers tend to give priority and become more accountable in delivering and reporting on these programmes.

Another key factor found to constrain governance functions of subnational structures is staffing related issues. Shortage of staffing, limited capacity and inadequate training were found to undermine the staff's ability to make decisions and to effectively deliver on their leadership roles [17, 25]. Moreover, this limited capacity has also been found to contribute to the underutilization of health information for adaptive learning and decision making [18, 23].

Regarding power dynamics, what has been seen as potential overreach of central political control - such as in the emergency response to the COVID-19 pandemic - can usurp the decision-space of subnational structures and also risk relegating communities to just users of services who are not engaged in planning and decision making [19]. In the face of these cross-cutting issues largely negatively impacting subnational governance, the review also found positive impact from deliberate effort towards strengthening leadership capacity, building stronger systems and effective delegation of authority [21, 23].

Interpreting Performance across Governance Domains

Overall, synthesizing the evidence shows that the performance of subnational governance structures is mostly portrayed negatively across governance domains. This includes accountability deficits and transparency gaps at district and facility levels. Effective decentralization and decision-space remain, to

a large extent, a theoretical concept, with incomplete delegation of authority to subnational structures being a common feature. While community participation through HCCs shows potential, this is hampered by inadequate capacity and resources. However, positive lessons are apparent, especially from studies focusing on evaluating pilot health governance or programme specific initiatives.

Discussion

This scoping review is based on 10 studies which examine Zimbabwe's subnational health system governance. Consistent with most similar studies from LMICs, the findings show that subnational structures are mostly functionally constrained, with persistent gaps across all governance domains and across all levels of subnational health governance. Additional similarities are observed where dedicated efforts to enhance governance have produced tangible results, with recommendations for sustainable efforts towards long-term gains.

Assigned but not Capacitated

This review observed that on paper, the subnational health governance structures are established and recognized as existing, but that existence is often not accompanied by the requisite capacity building. This is corroborated by evidence from other LMICs such as Nigeria and Ethiopia where subnational healthcare leaders were found to have a gap in skills or expertise to deliver on their functions, and also demonstrating that where leadership capacity is weak, performance will be poor [26, 27]. The evidence from the review, however, also shows that it is possible to enhance governance across different domains through deliberate effort [23], with global evidence reinforcing this finding, noting that developing leaders through structured capacity building can translate institutional mandates into practical action and deliverables for health governance [28].

Incentives Introducing Governance Bias

This review found that there can be unintended negative consequences on subnational health governance due to some health system financing models which introduce bias towards better resourced programmes or those that have stronger donor requirements [22, 23]. This is consistent with other evidence which demonstrates how certain reforms or strategies - particularly those with some financing attached to them - may entrench control from superiors while undermining social accountability [29]. This distortion has the potential of undermining cohesion at the local level, where a single programme's strength may create disharmony, and negatively affect the broader health system.

Transparency Gaps Undermine Governance

From this review, it was observed that unclear resource management, procurement or staffing processes were major transparency gaps at the subnational level [16, 18]. Evidence from other literature shows that where transparency and integrity is compromised, governance performance and outcomes are also compromised [30]. On the other hand, evidence from the review aligns with other global evidence which shows that institutionalized transparency approaches have potential of improving governance functions within programme specific context, such as the Good Governance for Medicines [21, 31]. However, these programme specific mechanisms risk remaining as siloed 'white elephants', unless deliberately integrated into the wider health system. If appropriately positioned, these strategies can serve as entry points or 'pilots' to generate evidence to inform system-wide subnational health accountability reforms.

Partial Delegation Scuttles Effective Decentralization

In addition to findings from this review on partial delegation, evidence from other Sub-Saharan African countries points to more

sensitive complexities and sometimes political connotations which are seen as both cause and consequence of partial delegation [32]. This has been seen to undermine trust and confidence, resulting in weak relationships between central level policy makers and subnational implementers [33].

Observations from this review also mirror other global evidence, which shows that even those systems with advanced decentralization, are also at risk of re-centralization in the face of crises with need for control and coordination being main justifications [34]. Evidence from this review contradicts this notion, demonstrating that equipping subnational teams and expanding their decision space – not control – could in fact enhance their governance performance, even in the face of public health challenges [23].

While a general observation from the review and other LMICs is that decentralization and decision space are desirable, developed countries such as in Europe present a paradoxical position, with governments seeking to re-centralize, arguing the need to facilitate more coordinated efforts and alignment of strategies across subnational jurisdictions [35]. This raises the question of further research on whether the ideal is to fully or partially decentralize as a recommendation, and whether the recommendation would be the same for developing countries and the more developed countries.

HCCs' Untapped Potential

The role of community participation in health governance is widely accepted as a critical factor, especially for fostering social accountability to service users. While global evidence [36] – in line with findings from this review – notes that participatory health governance is most effective at the local service delivery point, it also recognizes that participatory health governance needs to be strengthened at the district or provincial levels as well. Moreover, it is observed that regardless

of how strong the HCCs may be, they have limited influence on decisions made at the district level. WHO [37] bemoans the risk of the voices of the HCCs being ignored, especially when their district or provincial levels do not have similar structures. Consequently, the potential of HCCs risks remaining under-utilized.

Crosscutting Structural Factors Constrain Health Governance

One revealing finding from this review was that determinants of governance performance and drivers of governance challenges go beyond individual domains. They are influenced by several underlying, cross-cutting structural barriers which include challenges with financing and resource management, influence from external players, power dynamics, human resource gaps among others [18, 22]. Similar challenges have been reported in other African countries, where dependence on external funding, administrative inefficiencies, and poor organizational culture of performance have been found to undermine subnational health governance [38]. Moreover, weak information management and poor data usage at all governance levels have deprived managers of the requisite tools to drive evidence based and adaptive decision-making and governance.

Implications for Policy and Research

The number of publications included in this review is a genuine indication of a dearth of evidence on subnational health governance in Zimbabwe. It raises attention on the need for more research on this topic more broadly. More specifically, future research will need to explore how different governance domains – individually and collectively – impact health service delivery and health outcomes, to help determine prioritization for quicker gains. Moreover, the multi-level relationships between different governance levels need to be studied, to gain insights on how their

interactions affect both their governance performance and service delivery.

The findings also challenge the authorities to support and facilitate holistic and meaningful delegation to subnational structures. It also invokes on all actors' agency, towards enabling meaningful contribution of community level governance platforms for not just their local level, but for system wide impact. The review also brings out the need for systems-thinking, beyond individual governance domains, towards addressing health governance issues in the context of other structural factors that affect them.

Conclusion

This scoping review mapped and synthesized the available evidence on subnational health governance dynamics in Zimbabwe. The review found that accountability, stewardship and leadership, community participation, decentralization and decision space emerging as the most frequently examined domains, often affected by systemic challenges such as financing, staffing, and power dynamics. Health governance was frequently characterized as weak, fragmented, constrained, or inadequately resourced across all subnational levels throughout the period under review, suggesting persisting challenges throughout the period.

Beyond highlighting governance dynamics, this review also revealed that there is relatively scant empirical research on subnational health governance in Zimbabwe. The available literature remains unevenly distributed across governance domains, levels of the healthcare system and geographical settings. This paucity of evidence limits what conclusions can be made about the state of subnational health governance and stifles decision making on policy or practice. Nonetheless, the consistency of findings across studies points to the need for sustained efforts to strengthen subnational health governance across all domains and across all levels.

The evidence base points to the need for more empirical research on subnational health governance broadly, with more focus on the underexplored domains. More robust research could: assess the impact of specific domains – individually or in combination - on health service delivery and outcomes; multi-level dynamics, and determinants of subnational health governance performance. Research could also generate more robust evidence on the functionality, effectiveness and outcomes of subnational health governance structures.

Such evidence will be essential for informing governance reforms and supporting the development of more responsive, accountable, and effective subnational health systems in Zimbabwe.

Conflict of Interest

The author declares no conflict of interest.

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Ethical Approval

This study utilizes published literature and does not involve human participants; hence ethical approval is not required. However, good research practices were adhered to in managing the study.

Data Availability

The datasets generated during the current study are available from the corresponding author upon reasonable request.

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Author Contributions

Mufaro Chiriga conceptualized and designed this scoping review, carried out the data

collection and analysis, as well as preparation of the manuscript.

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