PERCEPTIONS OF HEALTH PROFESSIONALS ON THE CHANGES BROUGHT ABOUT BY HEALTH SYSTEM REFORMS IN ZIMBABWE

by

CHARLENE RUDO DEVE

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SUPERVISOR: PROF RM MMUSI-PHETOE

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Student number: 61948705

DECLARATION

I declare that the dissertation entitled **PERCEPTIONS OF HEALTH PROFESSIONALS ON THE CHANGES BROUGHT ABOUT BY HEALTH SYSTEM REFORMS IN ZIMBABWE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

13 May 2020

SIGNATURE **DATE**

Charlene Rudo Deve

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STUDENT NUMBER: 61948705
STUDENT: CHARLENE RUDO DEVE
DEGREE: MASTER OF PUBLIC HEALTH
DEPARTMENT: HEALTH STUDIES
SUPERVISOR: PROF RM MMUSI-PHETOE

ABSTRACT

The purpose of this study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe. Qualitative, explorative and descriptive research was conducted to identify concerns of health care provision, as described by health professionals in Zimbabwe, and to provide awareness for future reforms. Data collection was done using semi-structured interviews. Ten health professionals from two study sites participated in the research. The findings revealed that health professionals have an understanding of health system reforms and how these have changed the way health services have been delivered over the years. There is a general outcry among health professionals regarding the deteriorating provision of quality health care amidst the challenges that the health system is facing under a collapsing economic situation. The study recommends inclusion of health professionals in policy making as well as timely dissemination of any information regarding changes in policy. The study also recommends further research on the same topic with a larger diverse group of participants.

Keywords

Change; health professionals; health care provision; health system; health system reforms.

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Dedication

I dedicate this study to the version of me that is often afraid to tackle new adventures. Have faith in God and in the gifts and talents He has given you. Nothing is impossible.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
DHS	Demographic Health Survey
EDC	Director of Epidemiology and Disease Control
ESAP	Economic Structural Adjustment Programme
FP	Family Physician
HC	Health Centre
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
ISCO	International Standard Classification of Occupations
MDGs	Millennium Development Goals
MDR	Multi-Drug Resistant
MERP	Millennium Economic Recovery Programme
MICs	Multiple Indicator Cluster Surveys
MoHCC	Ministry of Health and Child Care
PMTCT	Prevention of Mother to Child Transmission
NEHS	National Eye Health Strategy
NEML	National Essential Medicines List
NERP	National Economic Revival Programme
NPM	New Public Management
PHC	Primary Health Care
SAP	Structural Adjustment Programme
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
WHO	World Health Organization
ZACC	Zimbabwe Corruption Commission
ZDHS	Zimbabwe Demographic and Health Survey
ZimAsset	Zimbabwe Agenda for Socio-Economic Transformation
ZIMPREST	Zimbabwe Programme for Economic Social Transformation
ZWD	Zimbabwean Dollar

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This study was aimed at exploring the perceptions that health professionals have of the changes that have been brought about by health system reforms in Zimbabwe. Chapter 1 begins by outlining the background to the research problem and presenting the aim of the study, the significance of the study, and definitions of terms. The research design and method are presented, along with the scope of the limitations of the study. Finally, the structure of the dissertation is outlined.

1.2 BACKGROUND INFORMATION OF THE RESEARCH PROBLEM

Health system reform is a problem-solving process that seeks solutions to significant challenges within the health system. It involves many institutions and stakeholders, including health professionals as human resources and brain muscle. Health system reforms rely heavily on health system research information. This study thus aimed to provide information regarding the different perceptions that health professionals have of health system reforms.

After Zimbabwe attained independence in 1980, the government invested heavily in health, in line with its commitment to address inequalities within the health system, particularly in the rural areas (Buzuzi, Chandiwana, Munyati, Chirwa, Mashange, Chandiwana, Fustukian & McPake 2016:6). In the first decade post-independence, there was modest but steady growth of the economy and a decline in incidences of absolute poverty as household incomes slightly increased in the same period (Muvunzi 2015:2). Zimbabwe's health indicators, such as infant and child mortality rates, improved rapidly through various programmes implemented as a drive to provide health care to the majority of the population (Muvunzi 2015:4). The government also directed more funds into a range of cost-effective preventive health programmes such as immunisation against childhood diseases, the establishment of family planning clinics, nutrition programmes and maternal health services (Mhike & Makombe 2018:4).

Moreover, a village health worker programme was initiated in the 1980s as a community health model to educate villagers and train health workers (Kidia 2018:2).

The first decade post-independence (1981-1989) was recognised as a period of redistribution which marked improvements in socio-economic development (Sibanda & Makwata 2017:5). Raftopoulos (2004) in Mate (2018:2) described the first decade of independence as a period of “restoration and hope” in which the ruling party promised to expand social services. However, several problems were identified in late 1980, which saw the deterioration of the economic infrastructure. Recurring droughts hit the country in 1980/81 and 1984/85, which decreased the economy’s performance based on agriculture. There was also a decline in investment in mining, resulting in budget deficits, unemployment, reduced production, as well as the devaluation of the Zimbabwean dollar (ZWD) (Mate 2018:3, 6). In light of these problems, the International Monetary Fund (IMF) and the World Bank recommended that Zimbabwe adopts the market-friendly Economic Structural Adjustment Programmes (ESAPs). Structural Adjustment Programmes (SAPs), as explained by Muvunzi (2015:1), were introduced by the northern governments to offer aid to African countries in a debt crisis. ESAP was therefore introduced in Zimbabwe in October 1990, and started in March 1991 until 2000 (Mate 2018:13). However, Muvunzi (2015:2) argues that Zimbabwe was not in an economic crisis when ESAP was introduced, and its adoption was meant to accelerate economic development and meet the needs of a growing population. Structural programmes are administered by IMF and the World Bank as they lend financial assistance to countries facing dire macro-economic imbalances (Thomson, Kentikelenis & Stubbs 2017:3-4). In the case of Zimbabwe, Mate (2018:13) cites Mhone (1995) and Brett (2005) as stating that ESAP was introduced to reorient the economy towards growth.

The state of the public health sector during and after the adoption of economic reforms in 1990 mirrors the current state of affairs within the sector. According to the Health Development Fund (Ministry of Health and Child Care [MoHCC] 2015:1), the main challenges facing Zimbabwe’s health care system were, and remain, a loss of professionals, a demoralised workforce, lack of medicines and medical equipment, and outdated policies and facilities that are unable to cater for their running costs. The near-collapse of the health system in 2008 saw the health sector battling with public health issues such as waterborne diseases, immunisation coverage and nutritional

deficiencies, which revealed shortcomings in the system. Some of the challenges mentioned above were a result of limited access to health services and the burden of communicable and non-communicable diseases (Ministry of Finance and Economic Development 2016:83).

Government has attempted to address some of these issues through various policies and programmes, such as the National Health Strategy 2009-2013. Mugwagwa, Chinyadza and Banda (2017:4) describe the National Health Strategy as frameworks and strategic direction that is useful for identifying and organising elements to be considered in policy implementation within the health system. However, this, in itself, does not explain or predict behaviour or outcomes, but only points to the vision carried by the government for the re-development of the health system.

The proposed yearly health budget for Zimbabwe is predicted to respond to the health challenges identified through a consultative process of health allocations. The Ministry of Finance and Economic Development (2016:83) allocated 6.88% of the 2017 total budget to combat the health issues mentioned earlier. However, this allocation falls short of the Abuja Declaration threshold stipulated at 15% of the total budget, and the World Health Organization (WHO) per capita health expenditure of US$34. Further analysing this situation, more than three-quarters of the budget is used for salaries, which leaves the procurement of medicine and medical equipment to donors (Ministry of Finance and Economic Development 2016:13). This inefficient and inequitable allocation of resources compromises the provision of health services.

1.3 RESEARCH PROBLEM

The introduction of economic reform policies led to the deterioration of health indicators. Health indicators are essential for the assessment of a country's socio-economic development and quality of life. Within the Zimbabwean context, major health indicators were threatened by significant changes in health care financing and organisation through economic reform policies (Buzuzi et al 2016:13). In the five years preceding the 2015 Demographic Health Survey, the under-five mortality rate was 69 deaths per 1000 live births and the infant mortality rate was 50 deaths per 1000 live births. The maternal mortality rate for the seven-year period before the 2015 DHS survey was 651 deaths per 100 000 live births. These statistics present the significance of health indicators for

the assessment of a country's socio-economic development and quality of life. For example, the maternal mortality rate can be used to assess the health status of a population, which is affected by prevailing influences such as health system reforms (Zimbabwe National Statistics Agency 2016:131, 343).

Given the statistics presented above, provision of quality health care in Zimbabwe has deteriorated over the years as shown by the health indicators. As already mentioned, this is deeply rooted in the economic reform policies introduced into the health system. Health professionals, an important part of the health system, need to be aware of the environment they work in and how it is affected by outside influences such as economic reform policies which may infiltrate into the health system hence affecting provision of health care. This led to the researcher's decision to explore health professionals' perceptions of the changes brought about by the health system reforms in Zimbabwe. This led to the researcher's decision to explore health professionals' perceptions of the changes brought about by the health system reforms in Zimbabwe.

1.4 PURPOSE OF THE STUDY AND OBJECTIVES

1.4.1 Purpose of the study

The purpose of this study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms. It was intended to create awareness of the concern related to health care provision in Zimbabwe.

1.4.2 Objectives of the study

The specific objectives of the study were:

- To explore and describe the perceptions of health professionals on the changes brought about by health system reforms in the public health sector.
- To identify the concerns of health professionals in providing health care in Zimbabwe.

1.4.3 RESEARCH QUESTIONS

The main research questions were:

- What is health professionals' understanding of health system reforms that have occurred in Zimbabwe?
- What are the health professionals' perceptions of the changes brought about by health system reforms in Zimbabwe?

1.5 SIGNIFICANCE OF THE STUDY

The findings from this study may be used to inform decision making related to health provision in future health reforms. The introduction of macro-economic reforms creates significant changes in other social sectors, such as the health sector, resulting in health care reforms which affect health care provision. It is therefore vital to study the changes created as a result of the reforms introduced into the health system. The findings of this study will thus help create awareness for future interventions in instances of introducing health reforms.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 Change

According to Ganti (2019), structural change refers to "a dramatic shift in the way an industry or market functions, usually brought on by major economic developments". The *Merriam-Webster Dictionary* (2018, "change") defines change as "to give a different position, course or direction to". For the purposes of this study, 'change' was used to describe the position of the health system as observed by health professionals before and after the introduction of health reforms.

1.6.2 Health professionals

According to the WHO guidelines of 2013, health professionals are health workers who maintain human health by applying principles and procedures of evidence-based medicine and care. They study, diagnose, treat and prevent ill health and disease according to the needs of the population they serve (WHO 2013:57). For this study, the

term ‘health professionals’ was used to refer to medical doctors, nursing professionals and other allied health professionals as listed by the International Standard Classification of Occupations (ISCO).

1.6.3 Health care provision

Health care provision is defined as the way resources such as medicine, staff and money and services dealing with treatment and diagnosis of diseases are pooled together to deliver health. The main aim for health care provision is to improve halth outcomes of a population (Intan, Noor, Azreena, Arinah, Musheer and Muhamad 2016:3). For this study, the concept ‘health care provision’ was used to describe the function and role played by the MoHCC and health professionals in clinical services and health promotion.

1.6.4 Health system

The WHO (2018a) gives a two-fold definition of a health system as being (i) all the activities whose primary purpose is to promote, restore or maintain health, and (ii) the people, institutions and resources arranged together in accordance with established policies to improve the health of the population they serve. For this study, the term ‘health system’ refers to all the people, resources and institutions pooled together by the Ministry of Health and Child Care to provide health care to the Zimbabwe population.

1.6.5 Health system reforms

A reform implies sustained purposeful and fundamental changes. A health system reform is a process of change that involves all the elements of health sector action based on a holistic view of the health sector (Marusic & Prevolnik Rupel 2016:226). The *Merriam-Webster Dictionary* (2017, “reform”) defines ‘reform’ as “to put or change into an improved condition”. Following this definition, for this study, health system reforms described a change or improvement in the activities put in place towards the promotion, restoration and maintenance of health.

1.7 THE RESEARCH DESIGN AND METHOD

Using a qualitative approach, an explorative, descriptive design was found to be appropriate in identifying concerns related to health care provision, as described by health professionals in Zimbabwe. The health professionals were further seen as being likely to provide rich data on awareness for future reforms. Kim, Sefcik and Bradway (2017:1-2) cite Polit and Beck (2009, 2014) as stating that qualitative research is descriptive in nature, particularly in examining health care. The approach is intended to describe different people through their experiences and gain insights from participants in understanding a phenomenon. Hence, this study adopted a descriptive approach to identify concerns related to the provision of health care, as described by health professionals in Zimbabwe, as well as provide awareness for future reforms.

The study took place in two of the largest hospitals in Zimbabwe, namely Parirenyatwa Hospital and Harare Central Hospital. These hospitals were deemed to have the largest number of health professionals who have worked in the sector since Zimbabwe's independence. The accessible population consisted of health professionals. To be included in this study, the participant had to be a health professional, either a registered or enrolled nurse, a medical officer or an allied health professional working at one of the two public hospitals mentioned. The health professional should have been working in a public hospital for a minimum of 20 years. The participants should have been able to converse in English as the official language in Zimbabwe used by all professionals.

The researcher used purposive sampling based on the eligibility criteria set for the study. The researcher obtained informed consent from all participants who accepted the invitation and then proceeded with individual interviews. The health professionals were selected on the basis of being well-informed about health reforms regardless of their rank. The research topic was considered to be familiar to the health professionals, thus they would have been able to provide relevant information for the study. The sample size was intended to be 15 participants; however, data saturation ultimately determined the sample size.

1.7.1 Method of data collection

Semi-structured interviews consist of several key questions or topics that guide the interview with follow-up questions, probes and comments. Semi-structured interviews

not only help to define areas to be explored, but they also allow the modification of the interview to best fit the context or pursue an idea in detail (DeJonckhree & Vaughn 2019:2). The researcher used semi-structured interviews for data collection (see Annexure D).

1.7.2 Method of data analysis

Template analysis was used to organise and analyse the richest and most detailed aspects of textual data according to themes. A detailed description of data analysis is provided in Chapter 3.

1.7.3 Ethical considerations

According to Polit and Beck (2017:210), there are three broad principles which inform standards of ethical conduct in research based on the Belmont Report. These are the principles of beneficence, respect for human dignity and justice. Throughout the study, these ethical principles were observed. A detailed description of the methodology that was used is provided in Chapter 3.

1.8 SCOPE AND LIMITATIONS OF THE STUDY

The study was based only in Harare, Zimbabwe. Finding participants who fit the inclusion criteria could have posed as a limitation due to the migration of health professionals to the private sector and other countries. One other limitation experienced in this study was the difficulty the researcher experienced in measuring the social effects of SAPs. It is often unclear what would have happened to the health system if Zimbabwe had continued with its policies without adjustment, which makes it hard to grasp the impact of ESAP fully.

1.9 STRUCTURE OF THE DISSERTATION

This section gives an outline of the organisation of the study. Chapter 1 introduced and gave an orientation of the study. A discussion and review of literature based on previous studies exploring this concept is provided in Chapter 2. Chapter 3 accurately reports on

the research design and methodology followed and any problems encountered. Chapter 4 specifies the exact procedures that were employed in analysing the data and discusses the research findings, including unexpected findings (if any). The conclusions of the research in relation to the research questions, specifically the problem statement, are provided in Chapter 5.

1.10 CONCLUSION

This chapter has introduced the study by looking at the purpose, objectives and significance of such a qualitative study. The next chapter explores the methodology used for this study. In this first chapter, the researcher presented an overview of the research. The researcher started the chapter with an introduction, then the background to the research problem, the aim of the study, the significance of the study, and the definition of terms were discussed. The theoretical foundations of the study were also introduced. The research design and method, along with the scope and limitations of the study, were also articulated. Finally, the structure of the dissertation was outlined.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses literature related to the research topic. The first section begins by describing trends in health care reforms around the globe and how these have affected the different health systems. The discussion tackles the reforms and their effects on health in the developed world, followed by the reforms in the developing world in general, before focusing on the adoption of health system reforms within the African region, as well as the sub-Saharan countries. The discussion centres on literature that describes reforms within the Zimbabwean health care system from independence until the introduction of ESAP and the effects thereof.

The chapter concludes with an overview of studies that have been conducted showcasing health professionals' perceptions of adopted health system reforms. It also puts the present study into context and how it fits into the existing body of knowledge.

2.2 GLOBAL HEALTH CARE REFORMS

Globally, the introduction of economic reform policies has had an impact on health systems and the provision of health care. This has been detected by taking a closer look at health indicators such as mortality and morbidity rates across health systems across the world. A study of health professionals' perception and understanding of health reforms and their consequences on health systems is therefore important to create awareness of the concern related to health care provision.

There is a wide variety of problems and constraints within health sectors that cross national boundaries which have pressured health policymakers to embark on health care reforms (Lundberg & Wang 2006:43). There is pressure from outside the health system, which affects the basic framework within which health-related policies are formulated. Then, there is a set of pressures arising from the existing health system itself and its challenges. In many cases, health system reforms occur as a result of

structural efforts to reform social sectors (*Medical Tourism Magazine* 2019). Moreover, there have been policy debates in both developing and developed countries with regards to health sector reforms since the 1970s (Lundberg & Wang 2006:51).

The WHO categorised health sector reforms into three generations, and Lundberg and Wang (2006:52) describe these categories as (1) concentrating on cutting budgets and encouraging the private sector; (2) public sector efficiency, decentralisation and managing human resource; and (3) improvements in service delivery and outcomes. Different parts of the world have generated their own ideas about health system reforms depending on the specific issues to be dealt with. The majority of issues that have arisen during health sector reforms include governance, management, human resources and provider payments (Lundberg & Wang 2006:53). Health system reforms are commonly characterised by changes in health financing and health system organisation. Health financing may involve cost recovery and user charges for publicly provided services. Conversely, changes in organisation may entail decentralisation and changes in ownership of service provision (Lundberg & Wang 2006:62). Central and South America, China, Africa, and East Asia are some of the regions that have tailored health sector reforms to suit the challenges they were facing.

2.2.1 National essential medicine system

China's health system reform began in early 1978 as the country embarked on an economic reform from a government-controlled system to profit-driven health care. Before 1978, health services were paid by health insurance with minimal out-of-pocket payments due to universal insurance coverage (Jin 2014:18). Jin (2014) explains that the health insurance system was categorised to cover rural populations, employees working in state-owned enterprises, government staff as well as university students.

After the economic transformation in the late 1970s, there was a collapse in the well-established medical system which affected both rural and urban residents (Sun, Gregerse & Yuan 2017:168). Local governments became responsible for providing local health care, and tertiary hospitals were pushed to over-utilise resources by enlarging infrastructure and importing medicine and medical equipment to attract more patients (Jin 2014:18). There was a mismatch in individual and government contributions to total health expenditures, according to Liu, Vortherms and Hong (2017:433), which resulted

in increasing out-of-pocket spending. Between 1978 and the 2000s, individual total contributions to total medical expenses increased to 60%, compared to government's contribution of less than 20% (Liu et al 2017:433). Most patients could not afford to pay out-of-pocket, hence a decrease in the utilisation of health services. Therefore, the main effect of the health system reforms introduced in early 1978 was unaffordable health services, especially for the poor and those in the rural areas (Jin 2014:19).

The Chinese government has implemented several policies since the late 1990s to combat the effects of earlier health system reforms. The main priority has been to provide efficient, convenient, secure and affordable health services (Jin 2014:20) to achieve the universal insurance coverage that was once available. To address the issue of financing, China established a basic medical security system that consists of three different medical insurance programmes, namely Urban Employee Insurance, Urban Resident Insurance, and Rural Resident Insurance (Liu et al 2017:433). The insurance programmes cover 90% of the population, including urban employees and retired employees, urban residents who are most likely uninsured, such as college students, children, elderly people without previous employment, unemployed people, immigrant workers and rural residents (Sun et al 2017:167). The introduction of the three government health insurance programmes has been described as the most successful policy pillar to achieve universal health coverage (Liu et al 2017:434). Overall, insurance improved access to medical care and increased utilisation of health services, including hospital admissions, hospital delivery and antenatal care (Sun et al 2017:175). Available data also show that between 2003 and 2008, insurance coverage rates dramatically increased from 27% to 87%, and coverage for the rural and urban population sat at 93% and 72%, respectively (Jin 2014:23). In 2002, less than 10% of the population in rural areas had medical insurance coverage compared to the 95% of citizens that had basic insurance in 2011 (Liu et al 2017:434; Sun et al 2017:167).

To improve the affordability and availability of medicine, China preliminarily introduced the National Essential Medicines List (NEML) in 1979 (Ding & Wu 2017:412). Jin (2014) explained that although this was a good initiative, poor availability of essential medicines in both rural and urban areas had the following financial implications, especially for patients without health insurance:

- Pharmaceutical companies lacked incentives to produce essential medicines due to the low profit margin.
- Hospitals whose main source of income was medicine also lacked incentives to stock essential medicine. As such, physicians prescribed expensive drugs rather than essential medicines, financially burdening patients.
- There was also a serious problem with the overuse and misuse of certain medicines, such as injections and antibiotics (Jin 2014:24).

The Chinese government officially launched the National Essential Medicine System following the 2009 reform announcement (Liu et al 2017:438) to tackle the above-mentioned problems. The NEML system cut the profit link between health institutions, doctors and medicine, by not allowing the 15% price mark-up from procurement to retail price (Liu et al 2017:438; Ding & Wu 2017:412). Only medicines selected by the NEML were permitted to be stocked and prescribed in community health centres, and nonessential medicines were not allowed to exceed 10% of the total items on the medicines list (Jin 2014:25; Ding & Wu 2017:412). A critical consequence of NEML reforms, according to a study by the WHO on drug availability, was a significant decrease in drug availability in Shaanxi, especially among EDL drugs (Liu et al 2017:439). The NEML system also reduced drug prices, particularly for patented brands, thereby reducing drug expenditures per visit. However, findings have suggested that practitioners may shift care to other services with greater financial gain, which has little impact on the overall cost of care (Liu et al 2017:438-439).

The NEML system has not succeeded in fully achieving its objectives. The NEML strategies should be fine-tuned to attract more patients to PHCs and reduce their economic burden (Ding & Wu 2017:412). Reforms should be systemically approached to avoid short-sighted reforms with a narrow focus, which may undermine any cost or quality gains (Liu et al 2017:443).

2.2.2 New public management reforms

In Europe, there has been an emerging trend of adopting neoliberal policies in the form of New Public Management (NMP) reforms, which is a movement evolving from the late 1970s and early 1980s, emphasising the role of public-private partnership within the health sector (Rosta 2011:6; Tabrizi, Goshayie, Doshmangir & Yousefi 2018:8). The

NPM theory emerged to improve efficiency and strengthen government accountability (Hammerschmid, Van de Walle, Andrews & Mostafa 2018:5). It has primarily been introduced in the United Kingdom and the United States, spreading across the globe to countries like Canada, Germany, Italy and Spain, with each country tailoring the NPM to fit its own institutional environments (Rosta 2011:6; Hammerschmid et al 2018:5). The main objective of NPM was to transform the traditional public administration to develop a more effective operation by transferring the managerial actions of the private sector and applying it in the public sector, and the use of market-mechanisms to achieve a similar level of efficiency (Rosta 2011:3; Tabrizi et al 2018:9).

NPM has been incorporated into the health sector in various economies around the globe, and is centred on improving the quality of health care and customer satisfaction by transforming patients into customers in a regulated competitive market. The NPM agenda for health care is to increase the role of private health service providers (Grosso & Van Ryzin 2012:495; Tabrizi et al 2018:8). The implementation of NPM was successful in a majority of developed countries although some principles failed (Tabrizi et al 2018:12). NPM reforms in the British health care system, where they have been deeply rooted, were characterised by contracting the management of public hospitals to private companies in an attempt to erode the boundary between public and private health care delivery. Health spending increased from 6.6% to 8.3% to 8.9% in 1997, 2005 and 2010, respectively, which benefits the majority as it mitigates inequities in revenue. This has, however, been an uneven and contested change (Simonet 2013:818-819). A study by Grosso and Van Ryzin (2012:494) showed that certain aspects of NPM that were applied throughout the United Kingdom's health system reforms seem to have improved citizen satisfaction and perceived performance of the health system.

Akhtar (2016) explains that the most important things to consider in the adoption and implementation of NPM reforms would be the country's context and nature, whether it is developed or developing. Generally, developed countries tend to meet these preconditions, such as well-functioning markets and economic development. On the other hand, developing countries are still struggling to stabilise their economies, and the introduction of neoliberal policies may cause instability (Akhtar 2016; Tabrizi et al 2018:12).

2.2.3 Family physician system

Turkey introduced primary care reforms similar to the reforms in former socialist European countries during the 1990s, which were mainly funded by the World Bank and supported by the WHO (Cevik, Sozmen & Kilic 2018:75). Prior to the reforms, Turkey's health system was unequal, with significant variations in health service coverage and health outcomes by regions (Hone, Gurol-Urganci, Millett, Basara, Akdag & Atun 2017:58). The historic health centre (HC) system began in 1961, and it depended on primary care services. Each geographical region consisted of a team with several physicians, nurses, midwives and technicians and people in the same region received health care services from the same doctor (Cevik et al 2018:74). The HC health system was plagued with inefficiencies, such as a high infant mortality rate of 26.1 per 1000 live births, shortages in both infrastructure and human resources (World Bank 2018a). In 2003, less than two-thirds of the population had health insurance, and among the poorest 10% of the population, around 76% had no insurance coverage. Together with out-of-pocket expenditure, this affected access to health care, leading to impoverishment (Hone et al 2017:59).

As a way to improve efficiency, universal coverage and patient satisfaction, the Turkish Ministry of Health reformed the health system from the HC system to the family physician (FP) system in 2003, under the Health Transformation Programme (Cevik et al 2018:75). FP services started in 2004 and involved individual family practices and an increased range of health services free of charge, including immunisations, family planning, monitoring of children and pregnant women, and regular annual check-ups (Hone et al 2017:58). Under the FP system, everyone could select their own family physician and the previously defined geographical borders in the HC system were now removed. A Community Health Centre was also established to provide public health services, such as cancer screening programmes and health promotion activities which were not supplied by family physicians (Cevik et al 2018:75).

As with all the other reforms that have been introduced within health systems around the world, it is crucial to analyse how these reforms have influenced health indicators. A study by Cevik et al (2018:75) compared health status indicators in Manisa province in Turkey between the HC period (2003 and 2007) and the FP period (2008 and 2012).

Although FP services started in 2004, they were only widely distributed across Turkey by the end of 2010. In the Manisa district, the transition to the FP system only took place in 2008 (Cevik et al 2018:75). Infant and child mortality rates increased significantly under the FP period from 9.2 to 14.5 per 1000 live births and 11.1 to 15.1 per 1000 live births, respectively (Cevik et al 2018:78, 81). Such an increase could have been due to improvements in recording practices, as issues relating to a lack of data in the HC period were reported in other studies. Thus, the increase in infant mortality rates was not necessarily considered a negative effect of health reforms (Cevik et al 2018:79). In fact, according to the World Bank (2018a), infant mortality rates across Turkey halved from 26 to 12 per 1000 live births, and life expectancy increased to 74 years. Moreover, in 2012 Turkey also recorded that 98% of the population had access to health care (World Bank 2018a).

A few other selected countries that underwent health system reforms as described by Lundberg and Wang (2006:61) are Colombia, the Czech Republic and Chile. Colombia reformed its health financing and delivery by establishing social insurance schemes in 1993 that allowed managed competition between public and private health institutions. Both public and private sectors were contracted for service delivery. In the early 1990s, the Czech Republic privatised state-owned public services, introduced a new payment mechanism and regulation organisation. Chile's health system reforms began in the 1960s; it progressed from universal health coverage through neoliberal reforms in the 1970s, a series of legislative reforms between the 1980s and 1990s to the last period of reforms (1990-2015) (Nunez, Manzano & Chi 2019:39). The last reform introduced a single supplemental benefit plan for both public and private insurance, with an emphasis on quality in health care provision and delivery. There was no significant improvement in equity in health, although the health reform is still underway, so its effects might be observed in the future (Nunez et al 2019:47).

It then suffices to conclude that different health system reforms across the world have been driven by various trends. Some of these trends, as shown from the above examples, include the economy of the country, average per capita income spent on health care costs and expenditure, the functioning of the insurance industry within the nation, and government support for the health care sector (*Medical Tourism Magazine* 2019).

2.3 REGIONAL HEALTH CARE REFORMS

By and large, policy initiatives in developing countries need to focus on the poor marginal population that is more likely to lack access to health services compared to those who are better off (Jin 2014:29). Poverty can create barriers to access to health services, and ill health can result and exacerbate poverty. Therefore, it is not surprising that developing countries have less access to health services compared to developed countries. Health expenditure is quite low at $30 for low-income countries compared to $3 039 in developed countries. There is also a wide disparity of indicators of health services across different countries, such as the availability of hospital beds and doctors per population. Four popular frameworks have been used to describe access to health care in developing countries, namely geographic accessibility, availability, financial accessibility and acceptability (Jin 2014:27, 30).

Africa has experienced the vicious cycle of poverty and ill health related to some of the limitations described above for developing countries' health systems. According to Ghanem, vice president of World Bank Africa, statistics show that the world population living in extreme poverty is 725 million, and more than half of these individuals are in Africa. The health systems of most African countries are in crisis, and the goal has become to invest in better health systems with a strong focus on maternal and child health, nutrition and female reproductive health, anchored in the frameworks described above (World Bank 2018b).

Sub-Saharan countries have therefore adopted reforms to rebuild their health care systems. Examples of countries that underwent health system reforms with significant results are Angola, Eritrea, Rwanda, Mozambique and Ethiopia. Three areas of health system reforms common among these countries, to varying degrees, related to decentralisation, health care workers, and health financing systems (Chol, Negin, Garcia-Basteiro, Gebrehiwot, Debru, Chimpolo, Agho, Cumming & Abimbola 2018:3). All five countries have undertaken steps relating to the shortage of health workers by introducing community health care workers programmes (Chol et al 2018:3). The current WHO recommendation is a minimum of 4.5 doctors, nurses and midwives per 1000 population. Community health care workers have also increased access to health services in geographically isolated regions. Rwanda further introduced a comprehensive Community-Based Health Insurance, which is a state-sponsored public financing

system that shields citizens from the effects of out-of-pocket health expenses. Such reforms have had a significant effect on the provision of maternal health services, resulting in a reduction in maternal mortality of over 50% (Chol et al 2018:5).

Tanzania went through an economic crisis which gained momentum in the late 1970s and early 1980s, and was under pressure from the international community to change its policies. The country adopted the first-generation SAP package within the Economic Recovery Programme from 1986 to 1989, followed by a second generation of reforms, which focused on institutional reforms (United Nations Development Programme [UNDP] 2017:62). Within social sectors in the context of health delivery, reforms led to the introduction of user fees.

Most low-income countries have a narrow scope for raising public revenue to finance health services through general taxation. The implication is that there is a limited amount of money that can be allocated from government budget to public health services, resulting in the introduction of other avenues of fund acquisition, such as user fees (Lundberg & Wang 2006:62). Tanzania first introduced the collection of user fees in July 1994, inspired by the policy of cost-sharing, which was aimed at raising revenue and eliminating unnecessary use of facilities; implying that households had to meet part of the cost of social services, including health (UNDP 2017:63). Harrington (2004:215) shares the same school of thought as the UNDP (2017:63) in terms of how the introduction of user fees led to a significant decrease in the use of health services. The poor, marginalised and women were particularly affected as they were denied access due to unaffordability of user fees.

All 46 countries in the African region of the WHO have introduced one form of health system reform or another, within varying contexts and contents. The influence has largely been poor performance of the health systems, particularly with regard to the quality of health provision. The focus of the present study is Zimbabwe’s health system, whose description follows in the next section.

2.4 ZIMBABWEAN HEALTH SYSTEM POST-INDEPENDENCE

After Zimbabwe attained independence in 1980, the government invested heavily in health in line with its commitment to providing free access to health care for all (Buzuzi et al 2016:16). This commitment was a step to remedy the imbalance of a colonial health care system that had imbalanced health services divided along racial lines. Priority was given to social sectors, and the total government budget for social sectors rose from 25.7% to 34.9% in 1980-81 and 1990-1991, respectively (World Bank 2001:4). In the 1980s and much of the 1990s, there was modest yet steady growth of the economy and a decline in incidences of absolute poverty (Muvunzi 2015:2), as the country was moving towards middle-income status (Nhapi 2019:155).

This led to the implementation of various programmes to provide health care to the black majority in rural areas (Muvunzi 2015:4). These included the initiation of health education for villagers and training of health workers; the establishment of family planning clinics; child nutrition programmes; and immunisation for childhood diseases became almost universal (Mhike & Makombe 2018:4; Kidia 2018:2). The listed programmes resulted in positive gains in the delivery of health services. Health indicators, such as the infant mortality rate and child mortality, improved rapidly; the infant mortality rate decreased from 86% to 66% between 1982 and 1992, respectively (Nhapi 2019:156). Household incomes increased somewhat in the same period (Muvunzi 2015:2). The government's commitment to primary health care (PHC) resulted in geographical accessibility to health services within rural areas. In the period 1981-1984, 360 new rural HCs were built, and 450 existing ones were upgraded (Buzuzi et al 2016:16). Moreover, up to 85% of Zimbabweans lived within 10km of a health facility by 1990, including those living in rural areas (Nhapi 2019:161).

An analysis of the economic policy in Zimbabwe from 1980 shows several distinct periods within the country's economy: government interventions (1980-1990), SAPs (1991-1995), restoration of government guidance (1997-2008), and the considerable confusion of the present (Nhapi 2019:157). According to Sibanda and Makwata (2017:3) who cite Gibbon (1995), Zimbabwe's economic and social policies can be grouped into four phases. From independence to 1982, there was an economic boom, and in 1982 to 1986, there were two significant economic recessions. The period 1986 to 1990 was characterised by a resumption of a degree of economic growth. The fourth period, which

began in 1990, was that of structural adjustment. Many more phases have been observed since 1995 (Sibanda & Makwata 2017:3).

A number of problems were identified in the early 1990s, which saw the deterioration of the economic infrastructure. Some of these problems were the 1990-1991 drought, HIV and AIDS, shortage in foreign exchange due to restrictions on foreign investments, inappropriate domestic policies, and mismanagement of public resources (Sibanda & Makwata 2017:6). In light of these problems, IMF and the World Bank recommended that Zimbabwe adopt market-friendly SAPS.

2.5 ECONOMIC STRUCTURAL ADJUSTMENT PROGRAMME (ESAP)

Of notable interest is the commonly referenced economic structural adjustment programme, called ESAP, introduced in October 1990 and started in early 1991, covering the period 1991 to 1995 (Kawewe & Dibie 2000:82; Sibanda & Makwata 2017:11). After public dissatisfaction with ESAP as it failed to meet its objectives, the government launched the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST) as a successor to ESAP (Sibanda & Makwata 2017:14). ZIMPREST was scheduled to cover the period 1996-2000 but only began in April 1998. According to Sibanda and Makwata (2017:15), Robert Mugabe, former president of Zimbabwe, described ZIMPREST's focus as being "to create employment, provide a firm basis for sustainable growth and equitable distribution of incomes". As already mentioned, the idea behind ZIMPREST was to build on ESAP and its moderate achievements. However, this plan fared poorly and there were no improvements within the economy; in fact, things got worse (Sibanda & Makwata 2017:15). The government thus introduced more economic rescue plans, namely Millennium Economic Recovery Programme (MERP) (2000-2001), the National Economic Revival Programme (NERP), and Zimbabwe Agenda for Socio-Economic Transformation (ZimAsset) from October 2013 to December 2018 (Sibanda & Makwata 2017:3). Of the above-mentioned economic policies and recovery strategies, ESAP had the most significant direct impact on Zimbabwe's health system.

According to Muvunzi (2015:2), Zimbabwe was not in an economic crisis when ESAP was introduced, and its adoption was meant to accelerate economic development and meet the needs of a growing population. ESAP was successful in liberating the

domestic economy and reducing restrictions on international trade. However, it failed to achieve its fiscal targets, partly due to the 1990-1991 droughts which reduced tax revenues by reducing drought-related incomes (World Bank 2001)

One of the major features of ESAP in Zimbabwe included removing subsidies for public social services and implementing cost-recovery policies. In line with this, in September 1980, government put an exemption policy in place based on income, which was set at a threshold of 150 Zimbabwean dollars (ZWDs) (Buzuzi et al 2016:23). Anyone earning below the threshold was entitled to free health care services, and in 1985, 90% of the population was estimated to earn less than the income threshold; thus, the majority of the population qualified for free health care. Consequently, there was a three-fold increase in clinic attendance around the country. However, there was little compliance to the income-based exemption rule in terms of who qualified for free health care or not, due to a lack of proper invoicing mechanisms at some institutions. The World Bank considered the system of exemptions as imperfect in achieving its equity objective (Buzuzi et al 2016:23).

The introduction of ESAP in 1991 meant the health sector was going to face a decline in budget allocation for the coming years. As a result, according to the World Bank (Buzuzi et al 2016:24), the fee schedules previously imposed now aligned badly with the actual costs of medical care; hence the Zimbabwean government was under pressure to reinforce its cost-recovery systems. The World Bank pleaded for an increase in the income threshold and changing the system for eligibility for free health care. The Ministry of Health then introduced cost-recovery policies in line with the aims of ESAP (Buzuzi et al 2016:24). Established initiatives (Bijlmakers 2003:68; Buzuzi et al 2016:24) included setting revenue targets, preparing a manual with user fees to be used by health facilities, a media campaign to inform the public of the fee schedule and the importance of adhering to it, educating staff, and developing a monitoring system. These initiatives were introduced without changing the previous fee schedule and the ZWD 150 income threshold. Only in late 1992 was the income threshold increased to ZWD 400 per month, which was justified considering inflation. Then, in 1993, there was a temporary abolition of user fee collection due to the 1991/1992 drought. Later within the same year, user fees were re-introduced at rural HCs (Bijlmakers 2003:68-69; Buzuzi et al 2016:24).

Over the years, there has been a change in the rationale for charging user fees. Initially, post-independence, the system was meant to enhance equity in health. With the implementation of ESAP, the focus shifted from equity to cost recovery and efficiency (Makate 2017:12). Nhapi (2019:163) argues that a part of the present problems within the health system is a result of introducing user fees through ESAP, which led to a decline in the delivery of social services.

Another key area that was affected by the introduction of ESAP was human resources. Health sector reform, under ESAP, focused on changes in financing, and neglecting the staff at different health institutions as key resources. Cuts in public expenditure negatively impacted salaries and incentives for health personnel. Health professionals thus decided to migrate to other countries in search of better remuneration and working environments, which left a gap within the public health sector as the state lost qualified personnel, increasing the number of unregistered practitioners required to fill the void (Muvunzi 2015:6).

The implementation of ESAP shifted focus from equity to cost recovery and efficiency. One of the central aims of PHC post-independence was improving maternal and neonatal health, and some of the gains before the introduction of ESAP were improved maternal and child health (Makate 2017:12). The achievement of PHC goals meant (i) the implementation of a comprehensive and well supported antenatal and postnatal care programme; (ii) the adoption of a national expanded immunisation programme; and (iii) the use of village health workers to monitor the health of children at community level. The increase in health facilities consequently improved access to health services, which coincided with a significant decrease in infant mortality between 1980 and 1990 from 100 to 50 deaths per 1000 live births (Makate 2017:11). Bijlmakers (2003:72) also acknowledged the decrease in infant mortality as one of the marked changes in health outcomes in the 1980s. The under-five mortality rate decreased from 104 to 75 deaths per 1000 live births in 1978-82 and 1983-88, respectively (Makate 2017:11). Moreover, an increase in child immunisation rates might also have improved awareness and access to services, thereby contributing to the lower infant and child mortality rates.

However, the introduction of ESAP meant some of the improvements in maternal, child and infant mortality rates were reversed. Observed trends showed a yearly increase in maternal mortality rates from 1987 to 1996, except in 1995, and a significant decline in

child survival prospects (Makate 2017:12). Zimbabwe is among the world's 50 worst performing nations in the area of child mortality. According to Makate (2017:10), United Nations Children's Fund (UNICEF) and the WHO, official mortality estimates revealed under-five deaths to be 71 per 1000 live births in 2015, nearly two times the overall target for the sub-Saharan region. Muvunzi (2015) mentions infant mortality rates rose from 23 to 36 per 1000 live births between 1990 and 2000. Additionally, 29% of under-five mortality in Zimbabwe is due to neonatal causes, and according to UNICEF (2015), most of these are preventable deaths. This reflects a significant gap in early infant diagnosis and treatments (Nhapi 2019:166). Similarly, Makate (2017:137) analysed child mortality rates using data from pooled Zimbabwe Demographic and Health Surveys (ZDHSs), and there is an unstable pattern in the mortality rates from 1990 to 2008; it appears that child mortality outcomes have worsened over time compared to 1990 levels. Another major contributing factor to under-five-mortality is HIV and AIDS, which contributes 21% to child mortality. In 2010, only 24 441 of the 89 490 HIV-positive children under 15 were on anti-retroviral treatment, and 680 of these were younger than 18 months (Nhapi 2019:166). The maternal mortality rate also increased from 238 to 1068 per 100 000 deaths in 1994 and 2002, respectively, along with infant mortality rates that increased from 54 to 62.25 per 1000 live births in 1990 and 2000, respectively (Muvunzi 2015). The increased infant, child and maternal mortality rates could be attributed to increased poverty due to structural adjustment and the increase in user fees for health services.

It is evident from the discussion thus far that the effects of SAPs have touched the entire framework of social sectors, including Zimbabwe's health system. Qualitative research was conducted through focus group discussions with nursing staff to understand the impact of SAPs on the quality of health care services in Zimbabwe beyond the issue of user fees (Bijlmakers 2003:127-128). All groups interviewed noted a marked decline in the quality of services since the implementation of ESAP in 1991 (Bijlmakers 2003:128). According to a study within the Chitungwiza and Murehwa districts, there was a growing concern and significant dissatisfaction among health professionals regarding deteriorating health services. This was characterised by shortages of drugs and medical supplies, long waiting times and high clinic fees, among other problems. Interviewed health professionals recognised that most patients had limited financial resources due to unemployment and increased cost of living. The commonly expressed wish was that user fees be lowered and the cost of medication be

included in the consultation fee (Bijlmakers 2003:128). Several studies, together with Bijlmakers' (2003) study, confirmed the frustration of both patients and service providers, and held the government responsible for the deterioration in the quality of health care. Studies such as the one conducted by Biljmakers are important as one of the key determinants of the success of health system reforms is the response and perceptions of health professionals.

2.6 CONCLUSION

It has long been established, based on this literature review, that there is a well-recognised crisis within health systems. The state of the Zimbabwean public health sector during and after the adoption of economic reforms in 1990 mirrors the current state of affairs within the sector. The main challenges facing Zimbabwe's health care system were, and remain, a loss of professionals, a demoralised workforce, lack of medicines and medical equipment, and outdated policies and facilities that are unable to cater for their running costs (Zimbabwe National Statistics Agency 2016:83).

Although plagued by these challenges and discouragement, health professionals have a genuine desire to improve public health and the health of patients, in particular. It is therefore pertinent to promote issues and policies that health professionals can actively engage in and support for the health system reforms to succeed (Lundberg & Wang 2006:67).

Much of the available literature on health policies have focused on the content of health system reforms, neglecting the actors involved in policy reform. Health professionals form part of these actors and occupy a position which makes them notice the impact of different policies within their health systems. However, knowledge of health professionals' perceptions of health system reforms is limited. Therefore, the present study explored health professionals' perceptions of the changes brought about by health system reforms in Zimbabwe.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter introduces and elaborates on the research design and methodological aspects which were used to conduct the study in order to meet the research objectives. Aspects of the methodology, such as research instruments, data collection methods and proposed methods of data analysis are discussed. Limitations, as well as ethical considerations undertaken during the research, are also considered in this chapter.

The purpose of this study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms. The method of data collection in this study identified concerns related to health care provision, as described by health professionals in Zimbabwe, and provided awareness for future reforms.

3.2 RESEARCH SETTING

Polit and Beck (2017:1043) define research settings as specific places where information is gathered. This study's setting consisted of two of the largest hospitals in Harare, Zimbabwe. Zimbabwe's health system operates on a pyramidal referral structure made up of clinics, district (secondary), provincial (tertiary) and quartenary hospitals. This study's setting consisted of two quartenary hospitals in the major urban centre of Harare, Zimbabwe. These serve as major national referral hospitals which provide specialist services such as psychiatry, eye treatment and gynaecology. Harare Central Hospital is situated in the Southerton District of Harare with 1200 patient beds and 51 years of experience. Parirenyatwa hospital has an excess of 5000 beds and has been in operation since 1890.

3.3 RESEARCH DESIGN

Polit and Beck (2017:98) define a research design as the overall plan for addressing a research question, including specifications for enhancing the study's integrity. The research design focuses on data collection at the site where participants experience the phenomenon under study, data analysis and its presentation (Creswell 2014:236).

3.3.1 QUALITATIVE APPROACH

A qualitative, exploratory and descriptive design was followed in this study. According to Du Plooy-Cilliers, Davis and Bezuidenhout (2014:174), qualitative researchers are interested in understanding human experience, including all the personal and distinctive characteristics of individual experiences and the meanings associated with a particular phenomenon. Most often in health care, qualitative methods explore complex phenomena encountered by health providers such as doctors and nurses, as well as policymakers and patients (Vaismoradi, Turunen & Bondas 2013:398). Brink, Van der Walt and Van Rensburg (2012:121) as well as (Leung 2015:324) state that the primary aim of qualitative research is to understand rather than to explain and predict phenomena.

As defined by Polit and Beck (2017:655), qualitative research is "the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design". The authors further explain how qualitative methods explore the full nature of a phenomenon, and in-depths methods can be used to describe the dimensions, variations and importance of the phenomenon. The researcher chose qualitative research for this study after reflecting on the nature of the problem, which entails the perceptions of health professionals on the changes brought about by health system reforms.

3.3.2 EXPLORATIVE APPROACH

The explorative, descriptive approach examines a situation as it exists in the current state (Burns & Grove 2017:165; Bhawna & Gobind 2015:49). According to Polit and Beck (2017:40), exploratory research begins where there is an interest of study and then investigates the full nature of the phenomenon. It is designed to shed light on the

various ways in which a phenomenon is manifested, and its underlying processes. Explorative research is most appropriate in addressing subjects where there is a high level of uncertainty and ignorance, and when the problem is not very well understood. It is, therefore, usually characterised by a high degree of flexibility lacking a formal structure (Polit & Beck 2017:40). The researcher explored health professionals' perceptions of the changes brought about by health system reforms.

3.3.3 DESCRIPTIVE APPROACH

Qualitative research is based on observation and experiences and is intended to describe differences among different people in understanding or perceiving a phenomenon through involvement in the actual experiences (Çekmez, Yildiz & Bütüner 2012:78; Bhawna & Gobind 2015:50). Polit and Beck (2017:304) explain how descriptive studies observe, describe and document a situation as it occurs naturally. Descriptive research provides an accurate and valid representation of the factors and variables relevant to the research question, making such research more structured. The researcher was interested in health system reforms and how they have affected the health system within the Zimbabwean setting. The study was thus designed to gain more information to identify the concerns related to health care provision, as described by health professionals in Zimbabwe, and to create awareness for future reforms. Therefore, the researcher found that a descriptive explorative design was the most suitable research design for this study as it could assist the researcher in describing health professionals' perceptions of the changes brought about by health system reforms.

3.4 RESEARCH METHODS

Polit and Beck (2017:1043) define research methods as techniques used to structure a study and to collect and analyse information in a systematic fashion. This section details sampling, the population and the data collection approach and method.

3.4.1 Sampling

According to Polit and Beck (2017:367) and Burns and Grove (2017:515), sampling involves selecting cases, a group of people, events, behaviours, or other elements with

which to conduct a study that represent an entire population. It can either be random or non-random. In this study, the researcher used non-random purposive sampling. Creswell (2014:253) and Polit and Beck (2017:693) describe that the aim with qualitative research is not to generalise findings to a population but to develop an in-depth exploration of the phenomenon of interest.

3.4.1.1 Population

A study population is an aggregate of elements sharing a common set of criteria (Babbie 2016:201). Polit and Beck (2017:365) add that a study population is the aggregate set of individuals or objects that have common characteristics in which the researcher is interested. The population is described in terms of the target population, inclusion criteria, and sampling method. According to Polit and Beck (2017:365), the accessible population is the population of people that fit the sampling criteria and are available for a particular study. This study was conducted in the two largest hospitals in Harare, the capital city of Zimbabwe. The accessible population consisted of health professionals, namely medical doctors, nursing professionals and other health professionals, who were 40 years old and older, and who had worked within the public sector over the past 20 years or longer. The researcher sought and was given permission to access the staff establishment by the Acting Chief Executive Officer at Parirenyatwa Hospital and the Chairman of Harare Central Hospital Ethics Committee (see Annexures B and C).

3.4.1.2 Eligibility criteria

Eligibility criteria specify population characteristics; that is, who is in the population (Polit & Beck 2017:366). To be included in this study, the participant had to be a health professional, either a registered or enrolled nurse, a medical officer or other health professional working at Harare Central Hospital and Parirenyatwa Hospital in Zimbabwe. The health professionals were selected based on being well-informed about the health reforms in the country, regardless of their rank. The research topic was considered to be familiar to the health professionals, thus they were able to provide relevant information for this study. In addition, the health professional had to have been working within the public hospitals for 20 years or longer, and be able to converse in English as the official language in Zimbabwe used by all professionals.

3.4.1.3 Sample size

A sample is a sub-set of the population elements, which are the most basic units from which data are collected (Polit & Beck 2017:367). Crossman (2014) asserts that, when conducting research, it is almost always impossible to study the entire population in which one is interested due to time constraints and cost. As a result, researchers use sampling to select a smaller number of representatives from a pre-defined population. The sample then serves as subjects for observation as a way to gather data as per the objectives of the study (Sharma 2017:749). As a result, researchers in qualitative studies use samples as a way to gather data with the aim to learn more about a phenomenon; the sample size is thus not considered as the most critical factor in qualitative research, but rather the richness of the information.

In this study, health professionals, as described above, were considered to be rich in information related to the objectives of this study. This characteristic influenced the saturation limit. The sample size was, therefore, not predetermined, but the estimated sample size was fifteen participants. Interviews were conducted until data saturation was reached. Data saturation is applied at the point when no new information emerges from study participants or when additional coding is no longer possible (Bradshaw, Atkinson & Doody 2017:4). In this study, saturation was achieved with the 10th participant.

3.4.1.4 Sampling technique

According to Creswell (2014:239), purposeful sampling is used to intentionally select individuals or sites from which to learn or understand a central phenomenon. The author also states that homogenous purposeful sampling entails purposefully choosing participants based on membership in a subgroup that has defining characteristics.

Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood (2015:2) and Bradshaw et al (2017:3) highlight that in qualitative research, purposive sampling is widely used to identify and select individuals who are knowledgeable and/or experienced with a phenomenon of interest. The other important thing to note with purposive sampling, according to Palinkas et al (2015:2), is the availability and willingness of participants as

well as their ability to communicate their experiences effectively. One advantage of purposive sampling is that it allows the researcher to create a sample based on their judgement and the researcher is justified in making generalisations from the sample under study (Sharma 2017:751). However, this type of sampling is prone to the researcher's bias. Participants in this study had to be health professionals working within the public health system for 20 years or longer to ensure they had enough experience and knowledge pertinent to the study; these specified inclusion criteria were adhered to. Cases that were deemed rich in information and that sufficiently answered the research question were obtained.

3.4.2 Data collection

Bradshaw et al (2017:4) explain data collection as a way of understanding and explaining a phenomenon, while Polit and Beck (2017:892) suggest that data collection is the gathering of information to address a research problem. Data collection is one of the crucial aspects of any research study (Du Plooy-Cilliers et al 2014:147). Athanasou, Di Fabio, Elias, Ferreira, Gitchel, Jansen et al (2012:88) highlight that the research question guides the data collection method. The data collection process for this study is described in the sub-sections that follow.

3.4.2.1 Data collection approach and method

Semi-structured interviews consist of several closed- and open-ended questions that not only help to define areas to be explored, but also allow the interviewer to follow up with 'why' or 'how' questions in order to pursue an idea or response in more detail (Gill, Stewart, Treasure & Chadwick 2008:237; Adams 2015:493). Polit and Beck (2017:720) explain that semi-structured interviews are used when a researcher knows what they want to ask but cannot predict the responses they will receive; hence, they prepare a written guide. The researcher developed and used an interview guide comprising mostly of open-ended questions with a few closed-ended questions related to participants' biographical information (see Annexure D). The questions in the interview guide simply directed the conversation to capture the health professionals' perceptions of the changes brought about by health system reforms. The interviews with the health professionals were conducted face-to-face in a private room. The researcher was the sole data collector and the data collection took place between July and September

2019. The interviews with the health professionals were conducted face-to-face in a private room and each interview was conducted in English for approximately thirty minutes at a time.

3.4.2.2 Development and testing of the data collection instrument

Polit and Beck (2017:899) define a data collection instrument as a device used to gather data. In this study, an interview guide was used for the face-to-face interviews. This interview guide was developed by the researcher. The interview guide was pre-tested to identify any problems with the data collection instrument and rectify, where applicable. Testing was conducted under conditions similar to the actual data collection setting, on a small scale with two participants. The participants were asked for their views after the interviews. After considering the feedback given by the participants, no changes were made to the interview guide.

3.4.2.3 Characteristics of the data collection instrument

The interview guide consisted of two sections. Section A comprised closed-ended questions that collected demographic data from participants including age, qualification and years of experience within the public hospitals. The open-ended interview questions in Section B were designed to solicit responses about the health professionals' perceptions of the effects of health reforms on the quality of health care services in Zimbabwe (see Annexure D). As a qualitative study, the data collection instrument was just a guide and participants were free to give as much information as they could, as long as it was in line with the main research question. In addition to taking notes, the researcher also audio-recorded the interview sessions to ensure verbatim accuracy.

3.4.2.4 Data collection process

Data collection only commenced after permission was granted by the relevant authorities at each hospital. At Harare Central Hospital, permission was granted by the Chairman of the Ethics Committee (see Annexure C), and at Parirenyatwa Hospital, permission was granted by the Acting Chief Executive Officer (see Annexure C). Data collection took place between July and September 2019. Once permission to conduct

study was granted, the researcher approached the unit managers of the different health professionals to be interviewed. The study was introduced to the unit managers and permission to approach health professionals was granted. The researcher then approached health professionals who met the sample criteria. The researcher explained to each participant that participation was voluntary, and they could withdraw from the study at any point. Consent was sought from the study participants prior to data collection; participants were asked to sign an informed consent form (see Annexure E). The researcher arranged an appropriate time and venue for the interviews to be conducted.

Information was obtained from the health professionals through face-to-face semi-structured interviews. A voice recorder was used with the permission of the participants to record the interviews to adequately and accurately capture all data. A private room was used for the interview sessions. Fifteen semi-structured interviews were conducted. This was an appropriate method for collecting rich, in-depth data, to explore and describe the health professionals' perceptions of the changes brought about by health system reforms in Zimbabwe.

Before each interview, the researcher explained the significance of the study to the participants and the importance of the data they were going to furnish. As stated earlier, the interview questions comprised both closed-ended and open-ended questions. Closed-ended questions were used to collect demographic data to describe the research sample and ensure participants met the sample criteria. Demographic data also ensured participants had diverse characteristics; for example, participants fell into different age groups. The open-ended questions allowed the interviewees to answer questions freely and provide new ideas and rich data. The researcher was also able to seek clarification and elaboration on data where necessary. To minimise limitations inherent in interviews as a data collection method, such as an unwillingness by participants to share information, the researcher selected only participants who were willing to be part of the study. Probing questions were used to encourage participants to share information. In cases where the participants did not clearly understand the question, the researcher rephrased the question so the participants could answer appropriately. Participants were given an opportunity to offer additional information once the researcher finished asking all relevant questions.

3.4.3 Data analysis

The data gathered from health professionals through face-to-face interviews were audio-recorded to ensure verbatim accuracy. The researcher also jotted down notes on the interview guide.

The analysis of qualitative data entails putting pieces of information together and conceptualising it into meaningful patterns. Data analysis typically starts with a search for broad categories and then themes (Polit & Beck 2017:755). Vaismoradi et al (2013:400) suggest that thematic template analysis is an independent and reliable qualitative approach to analysis. It relies on looking for pieces of information with similar content and meaning, as well as identifying how content differs from other information (Polit & Beck 2017:756). Sutton and Austin (2015:227-229), as well as Braun and Clarke (2006:87-88) identified specific steps to be taken during data analysis, which the researcher applied. Therefore, the following steps were taken during the analysis of data for this study:

- Familiarising with the data: This aspect entailed the researcher familiarising herself with transcribed data from the recording device, simply reading the data and making notes of any ideas that came to mind.
- Generating initial codes: Preliminary coding on a sub-set of the transcribed data allowed the researcher to identify any recurring ideas. Key themes that looked interesting and which contributed to the researcher's understanding were grouped together. During preliminary coding, *a priori* themes were defined according to the aims of the study and key issues drawn from previous research and literature within the field.
- Searching for themes: Template analysis was used to organise and analyse the richest and most detailed aspects of textual data according to themes. The researcher analysed a few transcripts extensively and developed an initial template.
- Reviewing themes: The key themes that emerged across early interview transcripts were organised into meaningful clusters and then defined in terms of how they related to each other. The researcher analysed data from further interviews using the initial coding template, parallel to on-going data collection.

The template was revised as long as was necessary until it covered all sections of encountered text.

- Defining and naming themes: The template was then finalised and applied to the full data set to aid in the overall interpretation of the data.

3.5 DATA AND DESIGN QUALITY

Validity is one of the strengths of qualitative research, and it is based on determining the accuracy of findings from the standpoint of the researcher, the participant or readers of the study (Creswell 2014:251). Leung (2015:325) defines validity as the "appropriateness of the tools, processes, and data". This includes demonstrating that the research question is valid for the desired outcome, the methodology is appropriate to answer the research question, the design is valid for the methodology, the sampling and analysis of data is appropriate, and the results and conclusions are valid for the sample and context of the study (Leung 2015:325).

To demonstrate the validity of qualitative data for this study, the researcher addressed issues of trustworthiness under the principles of credibility, dependability, confirmability and transferability (Bradshaw et al 2017:6). The researcher ensured she demonstrated trustworthiness from the inception of the research and throughout the research process.

3.5.1 Credibility

Polit and Beck (2017:787) cite Lincoln and Guba (1985) who describe credibility as "confidence in the truth of the data and interpretations of them". The two aspects of credibility stipulate that the researcher should conduct the study in a way that makes the findings believable, and secondly, demonstrate credibility to readers (Polit & Beck 2017:787). The researcher ensured the credibility of the findings by establishing and developing a trusting relationship with participants before the interviews. The researcher also summarised the responses given by participants to verify the accuracy of the interview transcripts.

3.5.2 Dependability

Dependability, like reliability and replicability in quantitative research, is the researcher's ability to describe the entire research process in a way that others can understand and follow, to reproduce the same research results in similar or different settings. Polit and Beck (2017:787) describe dependability as "stability of data over time and over conditions". It is the stability or consistency of the research findings and methodology over time (Moon, Brewer, Januchowski-Hartley, Adams & Blackman 2016:17). In this study, dependability was assured by addressing research questions that were entirely consistent with the specified research purpose. The use of audio-recorded interview transcripts and functional audio-recording devices addressed any distortions or inadequacy in portraying the phenomenon as expressed by the participants. The researcher also accounted for any changes that occurred in the study.

3.5.3 Confirmability

According to Brink et al (2012:127), confirmability ensures that the findings, conclusions and recommendations are congruent with the collected data. The authors further state that the researcher's interpretation and the actual evidence should be in harmony. Polit and Beck (2017:788) support Brink et al's (2012:127) definition that the analysed data should represent what was shared by the participants and that the researcher did not invent interpretations of such data. After describing the data gathering and analysis steps, the researcher reported the conclusions in detail and linked these conclusions to the data analysis. The researcher also ensured confirmability by submitting audio recordings and the original transcripts to an external coder to perform independent co-coding of the data. Input from experts in qualitative research, such as the academic supervisor, also maintained confirmability.

3.5.4 Transferability

Transferability refers to the extent to which the findings can be generalised and transferred to other settings, and it relates to the sampling and design issue (Polit & Beck 2017:788). The researcher ensured transferability through purposive sampling so that only those participants who had first-hand knowledge of the phenomenon under investigation actually became the primary informants. The researcher also ensured

transferability by providing a thorough description of the context of research, location, people studied, as well as processes observed during the inquiry to provide sufficient details so recreation could occur.

3.6 ETHICAL CONSIDERATIONS

3.6.1 Ethical clearance

To obtain clearance to conduct the research, the researcher submitted a research proposal to the University of South Africa (UNISA) Departmental Higher Degrees Committee and was thereafter issued with an ethical clearance letter (see Annexure A). To obtain approval to conduct the study at the hospitals, the researcher wrote a letter to the Acting Chief Executive Officer at Parirenyatwa Hospital and the Ethical committee at Harare Central Hospital seeking approval (see Annexure B). In these letters, the researcher stated her field of study, the research topic, the intended site of data collection, the purpose of research, the age group of the participants, and how data were to be collected. The researcher attached the research proposal and the UNISA ethical clearance (see Annexure A) to these letters. Approval letters were issued by the Acting Chief Executive Officer at Parirenyatwa Hospital and the chairman of Ethical Committee at Harare Central Hospital where data collection took place (see Annexure C).

3.6.2 Ethical principles

According to Polit and Beck (2017:210), there are three broad principles expressed in the Belmont Report, on which standards of ethical conduct in research are centred. These are the principles of beneficence, respect for human dignity, and justice.

3.6.2.1 The principle of beneficence

In order to uphold the principle of beneficence, it is the researcher's duty to minimise harm and maximise benefits (Polit & Beck 2017:211). The researcher ensured the well-being of the participants by protecting them from physical, psychological, emotional, spiritual, economic, social or legal discomfort and harm (Brink et al 2012:36). Care was taken in structuring the questions, and the interviewees were observed for any signs of

distress during data collection. Any participant who showed any signs of discomfort were allowed to verbalise their objections and reminded that the interview could be discontinued if it was causing intolerable uneasiness.

3.6.2.2 The principle of respect for persons

Respect for persons, as an ethical principle, is based on three convictions, namely individuals are autonomous and have the right to self-determination; individuals with diminished autonomy require additional protection; and in some rural African communities and religious groups, individuals might not be regarded as autonomous (Brink et al 2012:35). Polit and Beck (2017:212) explain how a potential participant can voluntarily decide whether to participate in a study without any consequences. Therefore, a participant has the right to ask questions, refuse to give any information or withdraw from the study. The researcher respected the individual's decision regarding whether they gave consent to participate in this study, and the decision to withdraw consent after the study commenced if the individual so wished. The participants were also informed that they could refuse to give information and that they had the right to ask questions relating to the study. The researcher did not use coercion or deception to obtain consent from study participants. The researcher also fully described what the study entailed, the person's right to refuse participation, and the likely risks or benefits of participating in the study.

3.6.2.3 The principle of justice

The principle of justice includes the right to fair treatment and the right to privacy. The right to fair treatment entails selecting participants based on the study requirements, not participant vulnerability. The right to privacy is maintained by ensuring that the research is not more intrusive than it needs to be and that data are kept in absolute confidence (Polit & Beck 2017:214). Privacy includes anonymity and confidentiality. Anonymity ensures that data obtained from participants in the course of the study will not reveal the identity of the participant. Confidentiality is a pledge from the researcher that any provided information will not be publicly shared with others and they will not be identified in any way (Polit & Beck 2017:223).

The selection of participants was based solely on those health professionals capable of giving rich information that answered the research question. That is, the selection was not based on availability, manipulability or friendship with the researcher to ensure that the selection was fair. To ensure privacy, the researcher conducted the interviews in a private room and used code names instead of real names. The individual interviews were once-off, meaning that there was no need for follow-up interviews with the same interviewees; hence, there was no need to use the real names of participants. In terms of demographical data, the interview guide only consisted of the participant's age, rank, period served in the department and highest qualification obtained (see Annexure D).

The participants' confidential details remained protected by identifying participants with codes and the final report on the findings combined responses from all participants without identifying individuals. The participants' identities were not revealed while the study was being conducted, reported or published. Only the researcher had access to the completed interview guides and the audio recorder, which were kept under lock and key. However, the researcher shared the processed data with relevant staff at UNISA since this study was conducted for academic purposes.

A confidentially binding form was signed by both the researcher and the participant (see Annexure F). Data collection only commenced after permission was granted by the Acting Chief Executive Officer at Parirenyatwa Hospital and the Ethics Committee at Harare Central Hospital (see Annexure C). Consent was also sought from the study participants prior to data collection (see Annexure E).

3.7 CONCLUSION

This chapter gave a detailed description of the research design and methodology used in this study. A description of the research setting and research methods that were employed, including sampling, population and the data collection approach and method, was provided. The data design and quality were also described with emphasis on the trustworthiness of findings. The chapter concluded by describing the ethical considerations adhered to in the study, and by discussing ethical principles.

The following chapter presents the in-depth data analysis, presentation and interpretation of the findings of the study.

CHAPTER 4

ANALYSIS, PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the results of the study and discusses the findings. The chapter is presented in two main sections. The first section denotes the participants' demographic data. The second section presents narrations from the transcribed interviews and discusses the main themes and subthemes that emerged from the collected qualitative data on health system reforms and the quality of health care services in Zimbabwe. The chapter further presents the findings from the study and analyses such findings.

Semi-structured audio-recorded face-to-face interviews were conducted with ten participants at Parirenyatwa and Harare Central Hospital between July and September 2019. The sample size for this study was not predetermined; the researcher used the principle of data saturation. When no new information emerged from the tenth participant – reflecting data saturation – data collection was terminated.

The purpose of this study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms. The specific objectives of the study were:

- To explore and describe the perceptions of health professionals on the changes brought about by health system reforms in the public health sector.
- To identify the concerns of health professionals in providing health care in Zimbabwe.

Based on the objectives, the effects of health system reforms on the quality of health care services in Zimbabwe and the experiences of health care professionals in this regard were explored. Hence, this chapter provides an analysis of the collected qualitative data, backed by quotations from participants to support the arguments.

4.2 DATA MANAGEMENT AND ANALYSIS

A total of ten interviews were conducted at the participating hospitals, namely Parirenyatwa and Harare Central Hospital, between 10 July and 10 September 2019. Six and four interviews were conducted at Parirenyatwa and Harare Central Hospital respectively. The interviews were audio-recorded to ensure verbatim accuracy. Raw data from the audio recordings were transcribed to MS Word documents before being analysed. All interview guides were kept under lock and key throughout data collection and analysis.

In data analysis and preliminary coding was conducted on a sub-set of the transcribed data, highlighting key themes that depicted the essence of the study and contributed towards the researcher's understanding. Themes were defined according to the aims of the study and key issues drawn from previous research and literature within the field. Template analysis was used to organise and analyse the richest and most detailed aspects of textual data according to themes. A few transcripts were extensively analysed to develop an initial template. The key themes that emerged across early interview transcripts were organised into meaningful clusters and then defined according to how they related to each other. The researcher analysed data from further interviews using the initial coding template parallel to on-going data collection. The template was revised as necessary until it covered all sections that were encountered. The template was then finalised and applied to the full dataset to aid in the overall interpretation of the data. The themes were used to describe the experiences and perceptions of health professionals regarding changes brought about by health system reforms.

4.3 RESEARCH FINDINGS

Only ten health professionals made up the sample. The demographic details of these participants are presented below, and each is given a pseudonym to protect their true identities as follows:

- Musa
- Rudo
- Paida

- Connie
- Pamela
- Mercy
- Simba
- Prudence
- Tendai
- James

4.3.1 Demographic data

This section presents the participants' demographic data. A full description of each participant's attributes which made them best suited for the study is given in Chapter 3. The demographic information covered the participants' age, qualification, rank/title within the institution, and the period they have worked in the hospital (years of experience). This section was used to describe the demographic variables of the sample and assess any influence on the research findings.

4.3.1.1 Participants' ages

The participants were asked how old they were at the time of participating in the interview. All participants responded to the question, as presented in Table 4.1.

Table 4.1 Participants' ages

Age (years)	Number of participants (Frequency)	Percentage (%)
40-49	1	10
50-59	7	70
60-65	2	20
Total	**10**	**100**

The health professionals' ages ranged from 40 years to 65 years. Only one participant (10%) was in the 40-49 years of age category, seven participants (70%) were between the ages of 50-59 years. Two participants (20%) were in the age category 60-65 years.

In this study, there was a correlation – up to a certain point – between age and number of years of experience at both Parirenyatwa and Harare Central Hospital. The older the

health professional, the more years of experience they had within the profession. This indicated that the younger health professionals most likely had not accumulated significant experience, depending on when they started working at either institution. However, as mentioned earlier, only two participants were older than 60 years which could be most of the health professionals retired at age 65.

4.3.1.2 Qualification

Table 4.2 presents the participants' qualifications.

Table 4.2 Participants' highest qualifications at the time of the interview

Participant	Qualifications
Musa	BSc Pyschology and MBChB (Doctor of Medicine and Surgery)
Rudo	Bachelor's degree in Nursing Science
Paida	Diploma in General Nursing and Opthalmic Nursing
Connie	Master's in Nursing Science
Pamela	Degree in Nursing Science
Mercy	Bachelor's degree in Nursing Science
Simba	Diploma in Laboratory Sciences
Prudence	MBChB (Doctor of Medicine and Surgery) and Master's in Public Health
Tendai	MBChB (Doctor of Medicine and Surgery)
James	MBChB (Doctor of Medicine and Surgery)

All interviewed participants were health professionals who fit the ISCO (WHO 2013). The study sample comprised of five nurses, four medical doctors and one laboratory technician in different departments within Parirenyatwa and Harare Central Hospitals. The recruitment of participants and interviewing was done until no new information was revealed and data saturation was achieved with a total of ten participants.

4.3.1.3 Rank/title of participant

Table 4.3 presents the participants' rank/title at the time the interviews were conducted.

Table 4.3 Rank/title of participants

Participant	Rank/title of participant
Musa	Acting Chief Executive Officer and Director of Operations

Rudo	Research nurse
Paida	Research nurse
Connie	Mental health unit manager
Pamela	Research and community nurse
Mercy	Registered general nurse and midwife
Simba	Laboratory technician
Prudence	Director of Epidemiology and Disease Control (EDC)
Tendai	General practitioner
James	General practitioner

The participants' position within institutions might have influenced the depth of knowledge in reference to this study. Participants who held positions of authority and decision making seemed to have greater knowledge regarding health system reforms in general and how they have affected the provision of health care.

4.3.1.4 Period worked in the hospital (years)

The participants were asked how many years they have been working within the hospital. Table 4.4 shows the period in years.

Table 4.4 Period in the hospital (years)

Period (years)	Number of participants	Percentage (%)
20-30	7	70
31-40	3	30
>40	0	0

Of the ten participants, seven (70%) had worked within the individual hospitals between 20-30 years, and the remaining three (30%) had 31-40 years of service. The following reasons may explain the data:

- Shifts of personnel within the health system from the public into the private sector in search of better working conditions. This would explain why there were fewer long-serving participants available at the time of the interviews.
- Immigration of health professionals to other countries for greener pastures, which makes the pool of long-serving professionals quite small.

- Retirement of health professionals after the age of 65, hence, it would have been difficult to find participants who had served in the public health system for more than 30 years.

4.3.1.5 Career paths

Participating health professionals were asked how many years they have worked within public health institutions and what roles they assumed over this period. Eighty percent of the health professionals worked within the same public health institution corresponding to the number of years worked in the respective hospitals where interviews were conducted. However, two of the participants had worked longer than the period served at each hospital.

The researcher felt this influenced the perceptions of interviewed participants. Having spent all, or almost their entire careers within the same health institution, the researcher believed the health professionals were in an excellent position to describe how health reforms have influenced the health system. Next, an overview of the research findings, categorised into three main themes and subthemes, is provided.

4.3.2 Themes and subthemes

Three main themes emerged from the participants' narrations. Subthemes that emerged from initial data analysis were clustered together from main themes, where applicable. The narratives included describing the health professionals' experiences with the delivery of health services, the introduction of health system reforms, states of health services before and after the introduction of health system reforms, and the current state of the health system. The main themes and subthemes were as follows:

Table 4.5 Themes and subthemes

Theme	Subtheme
1 Health care provision	-
2 Understanding health system reforms	2.1 Introduction of health system reforms 2.2 Health services before the introduction of health systems reforms 2.3 Health services after the introduction of health system reforms
3 The current health system	3.1 Shortcomings of the current health system 3.2 Strengths of the current health system

The researcher found that in some instances, there was an overlapping of themes. It was not always possible to separate themes, hence, a description of one theme at times referred to the contents of another theme.

4.3.2.1 Theme 1: Health care provision

Intan, Noor, Azreena, Arinah, Musheer and Muhamad (2016:2) refer to health care provision, as described by the WHO (2016), as the way inputs, such as money, personnel and medicines are combined to allow the provision of health services. The goal is to improve the population's health outcomes and decrease health inequalities. While narrating their experiences of health care provision, participants were willing to give as clear a picture as possible. Each of the health professionals was asked about their experiences regarding the provision of health services over the period they have worked in their respective hospitals. The most common recurring theme among participants was poor service delivery resulting mainly from a shortage of resources; that is, human, financial and other medical resources.

A participant's narrative captured some of these challenges:

> *Provision of health services has progressively gone down due to limited supply of resources including human resources…there has been a decrease in nursing staff in departments which has affected nursing care…there is a shortage of nursing equipment resulting in improvising when nursing patients which is not exactly ideal. (Rudo)*

James expressed his view on high staff turnover and staff shortages as the years have gone by, and said:

> *When I was doing my housemanship (medical internship) there was enough support in terms of human resources which made teamwork an essential part of health care provision…they have shifted and been absorbed into the private sector.* (James)

Many of James' colleagues in the field have either moved into the private sector or migrated to other countries in search of greener pastures – a phenomenon known as the 'brain drain' – leaving a significant gap within the system. The MoHCC has failed to provide attractive retention incentives to contain the loss of health professionals (WHO 2019). This is one of the problems leading to the current statistics of 1.6 physicians and 7.2 nurses for every 10 000 people (WHO 2019). Vacancy rates of over 50% for health professionals, such as doctors, midwives and laboratory staff, have also been recorded (Ministry of Health and Child Welfare 2009:4).

Mercy, a registered nurse and midwife, supported Rudo's narrative and stated:

> *The provision of health services was initially satisfactory but now deteriorating. It has been a struggle delivering quality nursing care with all the challenges in the health system.* (Mercy)

Pamela experienced the same challenges in delivering quality nursing care. She expressed:

> *Challenges in the health system are because of inadequate resources, for example, stationery to document patients' information, medication, low salaries and shortage of staff…these challenges have caused inadequate health care delivery resulting in poor quality of nursing care.* (Pamela)

Connie, a mental health unit manager at Harare Central Hospital, described her experiences by comparison. She said:

> *Initially, provision of mental health services was well run by co-ordinators who visited districts and clinics for follow-ups on services provided. There was also adequate and motivated supporting nursing staff that provided mental health care in the districts and clinics. One of the setbacks has been lack of resources such as transport to visit clinics hampering progress on follow-ups…there has been no funding for meetings and training programmes which was previously available…all these challenges have caused widespread apathy and lack of motivation among staff which has compromised on health services.* (Connie)

In his more than 20 years of service within the Harare Central Hospital, James experienced the ups and downs that have occurred in the delivery of health services. His thoughts were:

> *There have been improvements in certain areas within the system while others have deteriorated over the years…an increase in the establishment of clinics and district hospitals which is commendable as it provides ease of access to health services.* (James)

The established infrastructure mentioned by James has not been fully equipped over the years. Possible reasons were mentioned by other participants who pointed to a shortage of drugs, medical equipment and personnel. This poses a significant challenge because, even though the infrastructure is in place, it is of no use if there is a lack of essential resources required for health care provision.

There is an interlinking of a number of factors within health systems that impact the provision of quality health care; one of which is the availability of resources. To produce high-quality services requires high-quality inputs. It is evident from the narrations above that the health system has been plagued with a shortage of equipment and human resources. This has created a ripple effect in which a lack of resources frustrates health professionals, causing decreased productivity, further compromising the quality of health services.

Connie, who was previously a nurse tutor, experienced a change in the recruitment of nurses over the years, marked with nepotism. According to Murwira (2019), the Zimbabwe Anti-Corruption Commission (ZACC) embarked on audits exposing corrupt behaviour in recruiting trainee nurses. Systems audits and compliance checks were

carried out in six central hospitals, exposing bribery and corruption according to the ZACC spokesperson (Murwira 2019). This has resulted in the recruitment of nurses who have no commitment to the profession, as explained by Connie, negatively impacting the provision of quality health services.

Explaining how the character and personality of health professionals affect the provision of quality health care, Mosadeghrad (2014:77-89) indicated that the quality of health services depends on the health care providers' knowledge and technical skills. It is therefore vital for health professionals to improve their knowledge, attitudes and skills to deliver high-quality services. According to Connie, a lack of commitment from nurses in cases where proper recruitment channels were not observed results in professionals with poor knowledge and technical skills. As a result, this compromises the quality of services provided by these nurses.

Prudence and Simba had different narratives. Prudence viewed her experiences in the delivery of health services in a positive light. She noted:

> *Although shaken by a number of insults, the health system has a firm base which still remains…there has been a marked improvement in health indicators in the majority of the black population.* (Prudence)

Kidia (2018:1) agrees, and commented on how Zimbabwe's health system has retained its original foundations. This means the health system is relatively strong in comparison to other sub-Saharan African countries. It is then possible to rebuild and strengthen the health system from its original firm foundations. Simba similarly experienced good health service delivery over the years, with adequate resources and experienced workers.

The researcher identified that participants found it necessary to convey a clear picture and make the point that it has not been easy providing quality health services within a deteriorating health system.

4.3.2.2 Theme 2: Understanding health system reforms

Marusic and Prevolnik Rupel (2016:226) define reform as “sustained, purposeful, and fundamental changes”. According to the two authors, the consensus is that reform is a process of deliberate change. This view is supported by the WHO (2000:2), which states that a health system reform “is a sustained process of fundamental change in policies and institutional arrangements of the health sector, usually guided by the government”. Health system reforms can be divided into partial and global reforms. Partial reforms change only certain aspects of the system, which may result in day-to-day operational changes, while global structural reforms reshape the entire health system (Marusic & Prevolnik Rupel 2016:226).

Through this study, the researcher enquired about health professionals’ understanding of health system reforms. Participants were asked to describe a change or improvement introduced into the health system to promote, restore or maintain health, as an assessment of their understanding of health system reforms. All participants were asked about any reforms that have been introduced into the health system from 1990 until the date of data collection. Following this question, participants were asked to describe their thoughts on health care provision before and after the introduction of health system reforms.

There was a general understanding of health system reforms among participants. Most participants named at least one health system reform which aligned with literature.

4.3.2.2.1 Subtheme 2.1: Introduction of health system reforms

At independence, Zimbabwe inherited a health system with wide disparities in the distribution of health services among the population. Thankfully, the 1980’s independence ushered in a primary health approach together with other interventions designed to reduce these disparities (Zeng, Lannes & Mutasa 2018:301; Sanders 1992:52). Worldwide, countries that have introduced economic reform policies have impacted their health systems and the provision of health care. Zimbabwe has implemented several health policy interventions in response to problems within the health system. Since post-independence, the major interventions include the Plan for Equity in Health (1980), the ESAP (1991-1995), the National Health Strategy (1997-

2007, 2009-2013 and 2014-2016), Zimbabwe Programme for Economic and Social Transformation (1998), The Millennium Economic Recovery Programme (2001), and the National Economic Revival Programme (2003) (Mutokosi 2015:1; WHO 2009:1). The narratives that follow captured the participants' perceptions of the introduction of health system reforms.

As mentioned earlier, Prudence was of the opinion that the health system still stands on a firm base, despite the challenges it faced over the past few years. She claimed that one of the programmes that shook the health system was ESAP. She explained:

> *ESAP was an economic reform characterised by de-investing in social services as they were labelled as social consumers. It was therefore not prudent to invest in health as a social sector and there was a slackening of investment within the health sector and the results were telling in terms of health indicators.* (Prudence)

Musa and Connie both briefly mentioned ESAP as a health system reform in which government support towards the health sector decreased in terms of funding. One of the effects of reduced funding was the retrenchment of employees within the public service. Simba also mentioned ESAP as a health system reform and explained how it caused the migration of some health professionals to other countries, seeking greener pastures.

James identified ESAP as a reform programme introduced into the health system without dwelling on it in detail. He also recalled the cost-recovery policies introduced by the Ministry of Health, which eroded the previously imposed free health care for pregnant women and children under five. It was clear from the interview that he could not draw an association between ESAP and the later introduced cost-recovery policy. According to Buzuzi et al (2016:24), the Ministry of Health introduced recovery policies in line with the aims of ESAP, resulting in the establishment of user fees within public health institutions.

When asked about the reforms introduced into the health system, Pamela recalled a period when nurses within the City Health Department who were older than 60 years were retrenched; this had a significant impact on the health system. Inexperienced nurses were recruited to fill the vacant posts within the clinics around the city.

Numerous patients had to be referred from the clinics to hospitals for medical attention, and this increased the workload for the nurses stationed at referral hospitals. Pamela could not give a specific timeline in which this happened but only remembered it to be in her early years of practice. It is plausible to assume the retrenchment coincided with the introduction of ESAP; the focus of ESAP was to change financing within the health sector and cut public expenditure, resulting in some health professionals losing their jobs.

Mercy was aware of ESAP as a health system reform but could not offer more information on it. As discussed in Chapter 2, ESAP is the most commonly referenced SAP with a direct impact on the health system, thus the majority of the participants (70%) could at least name it.

The Zimbabwe Agenda for Socio-Economic Transformation (ZimAsset) was rolled out by government between October 2013 and December 2018 as an economic rescue plan (Sibanda & Makwata 2017:3). Musa recognised ZimAsset as a health system reform characterised by increased budget allocations to social sectors, such as health, with a focus on re-equipping and refurbishing hospital institutions. This was in contrast to ESAP, whose aim was to cut public expenditure, as already discussed. However, ZimAsset did not address the issue of the 'brain drain' resulting from ESAP, hence there remained a shortage of human resources.

The health system also reformed its management and administrative order, according to Musa. There was a change in management boards within public health institutions. This was characterised by a move from a pro-medical management structure, in which medical superintendents were heads of hospitals, to a new structure under the Health Service Act. The Health Service Act provided for the establishment of the Health Service Board, which was operational from June 2005. The Board was established to provide for the administration of public service delivery with a mission to "provide an efficient, effective and responsive health service delivery system through well-motivated, trained and dedicated staff" (Health Service Board 2018).

Paida, an ophthalmic nurse, identified Vision 2020 as a health system reform. According to her understanding, it was introduced to decrease the percentage of blind people by 2020. *Vision 2020: The Right to Sight* is a global initiative in conjunction with the WHO

and other founding members, launched in February 1999. The aim is to eradicate avoidable blindness by 2020. Zimbabwe's MoHCC, together with other key players, have made positive contributions towards Vision 2020 through the National Eye Health Strategy (NEHS) (2014-2018). The focus of NEHS was to reform and reorganise the way eye health services were delivered in Zimbabwe (MoHCC 2014).

Paida went on to explain what factors have hampered the implementation and monitoring of Vision 2020. She commented:

> *A lack of human resources as a result of brain drain has hampered the progress of Vision 2020…a lack of financial resources resulting in lack of transport to reach the different health facilities with some being in remote areas…lack of motivation among staff due to poor conditions of services has also hampered the success of Vision 2020.* (Paida)

Without giving much detail, Prudence mentioned the Health Transition Fund (HTF) and 100-Day Action Plan as health system reforms that have recently been introduced. HTF is managed by UNICEF to support Zimbabwe's MoHCC in "achieving the highest possible level of health and quality of life for all Zimbabweans", with special emphasis on women, infants, children and adolescents. It was designed to improve reproductive, maternal, newborn, child and adolescent health (RMNCH+A) and nutrition between 2016 and 2020 (UNICEF and Ministry of Health and Child Welfare 2011).

The 100-Day Action Plan was introduced when the current President of Zimbabwe, Emmerson Mnangagwa, came into power as part of his commitment to stimulate the economy in his first 100 days in office. After taking power, free medical care was introduced for children and the elderly in public hospitals. However, Mavhinga and Nyamande (2018), in one of the Newsday newspaper articles, commented on how the government did not back this claim with the clear and proper provision of financial resources to fund these free health services. They went on to comment that in the 100-Day Action Plan, the vulnerable groups were required to pay for services in public health institutions, contrary to what the President claimed.

Tendai mentioned the introduction of various basic health campaigns as health system reforms, which bore good results. Examples included the introduction of Blair toilets, village health workers and midwives.

James commented that *"there have been a lot of changes that have occurred within the health system".* Firstly, he mentioned the increased training of nurses and doctors as one of the reforms of which he was aware, without giving a clear indication of the period within which this was introduced. He also commented on the mushrooming of health institutions in the country as a health system reform. As already discussed in Chapter 2, this occurred in the early 1980s after Zimbabwe gained independence, to increase the majority population's access to health services in line with universal coverage. Overall, participants thus had good knowledge to varying degrees about health system reforms.

4.3.2.2.2 Subtheme 2.2: Health services before the introduction of health system reforms

Participants were asked to describe health services before the aforementioned reforms were introduced into the health system. Before the introduction of health system reforms, the system was gripped with pre-colonial atrocities. This was characterised by racial biases in which the system favoured the whites and mixed races over the black population. There were also biases in urban orientation and curative biased health care. Health service was characterised by skewed resource allocation and distribution processes which created several health challenges within the system.

Mutokosi (2015:1) cites Agere (1986) who noted that the infant mortality rate among the black population was high, at 120-220 per 1000 live births, in comparison to the 17 deaths per 1000 among the white population. The inequitable allocation of resources was consistent with numbers that showed 15% of the population used 44% of publicly funded services (Mutokosi 2015:1-2). A comparison of life expectancy between the black and white populations was also an indicator of the imbalanced health system. African males and females had a low life expectancy of 49.8 and 53.3, respectively; however, European males and females' life expectancy was 66.9 and 74.0, respectively.

In this study, participants were asked to describe health services before the introduction of health system reforms. Some of the participants could not give a clear distinction, and description of the health system before the reforms they mentioned were introduced. Most participants' narratives covered the period between 1980 and 1990, according to literature. This is a period in which Zimbabwe's economy was on its way to middle-income status. The government invested heavily in the health system and introduced primary and preventive health care as the backbone of the system.

Paida gave a detailed response pertaining to the state of the health system before ESAP was introduced. She explained:

> *The incoming government's focus post-independence was to achieve health for all by 2000. There was an establishment of new health facilities so as to improve geographical access to health services.* (Paida)

According to Buzuzi et al (2016), 360 new rural HCs were built, and 450 existing ones were upgraded between 1981and 1984. Moreover, up to 85% of Zimbabweans lived within 10km of a health facility by 1990, including those living in the rural areas (Nhapi 2019:161). Tendai agreed that "*there was good access to health services".*

According to Prudence, increased access to health services improved health indicators among the majority of the black population. Nhapi (2019:156) supports this notion by indicating that health indicators, such as the infant mortality rate and child mortality, improved rapidly. The infant mortality rate decreased from 86% to 66% in 1982 and 1992, respectively.

Apart from improved access to health services, there was also decentralisation of many aspects of health delivery post-independence, according to Prudence and Tendai.

Prudence stated:

> *There was part decentralization and part devolution by the incoming government to achieve health for all by 2000.* (Prudence)

Health system decentralisation is the transfer of power from higher central government to local government. Conversely, devolution is the transfer of decision-making power from central government to local governments to create layers of governments with the authority to perform clearly-defined functions (Bvirindi & Chikwawawa 2019:785).

Masvaure (2016:82-83) explained what decentralisation looked like in the first decade post-independence. Significant developments in decentralisation were introduced in 1984, creating a new order of command from the village level to the national government level. The aim was to bring the government closer to the people and allow the citizens to have a say in the development decisions taken by local authorities. Decentralisation of Zimbabwe's health services meant that health care was provided at primary, secondary, tertiary and quaternary levels. The decentralised structure of governance allowed for various health offices to exercise authority over health facilities that provided services to their targeted areas. However, the policy and administrative guidance still came from the central government.

The introduction of ESAP enforced decentralisation with a different strategy. The aid organisations funded the decentralised institutions directly rather than channelling the funds through local government. The objectives of ESAP in decentralisation were to reduce the role of government in the economy and reduce government expenditure (Masvaure 2016:84). The government reluctantly complied with these objectives as it meant deviating from what they wanted decentralisation to look like before the introduction of ESAP.

As discussed in Chapter 2, one of the effects of ESAP was the retrenchment of workers in line with budget cuts within social sectors, including the health system. Connie believed before the effects of ESAP hit the City Health Department and other public institutions, patients trusted the public health system. Both public hospitals and clinics were well staffed with experienced employees. According to Simba, before the introduction of ESAP, the public had access to an efficient health system. There were adequate resources, including human resources and medication. There was also the availability of donor funds to drive critical projects within the health system. Without giving a clear timeline, Tendai noted:

> *…there was a point when there was free health care for all.* (Tendai)

The researcher considered this to be the period post-independence when the government was heavily invested in its commitment to providing free health care to the population. An exemption policy based on income was implemented, and 90% of the population earned less than the set threshold; therefore, the majority of the population qualified for free health care (Buzuzi et al 2016:23). Tendai also mentioned the good referral system that was in place, which allowed for better access and provision of health services at each level.

4.3.2.2.3 Subtheme 2.3: Health services after the introduction of health system reforms

Participants were asked how health services were affected after the introduction of reforms in the health system. According to Mutokosi (2015:1), health system reforms were implemented in response to health problems and the interventions were mainly formed by the 1978 Alma Ata Declaration. The government of Zimbabwe introduced different programme solutions to combat issues such as equality, mortality, human workforce, finances and service delivery.

A study was done in Nyanga district to explore the perceptions of community health workers on the barriers to providing services. According to the results, the main barriers to the provision of health services related to accessing health services, high workload and the large geographical areas they were expected to cover. All these challenges threatened the equity and quality of health services provided to communities (Darikwa 2016:62). The narratives that follow explain health professionals' perceptions of health care provision after the introduction of health system reforms. Some of these narratives capture the barriers expressed by community health workers in the study done by Darikwa (2016).

ESAP was introduced in early 1990 and, according to Prudence, during this period, the economy was performing well. In the years following the roll-out of ESAP, health indicators declined as the government slackened investments in health. Unfortunately, it seemed Zimbabwe spiralled downhill as things got worse; both within the health system and other social sectors. There was a multisystem collapse between 2000 and 2008, which caused another shaking of the health delivery system. The countrywide shortage

of fuel affected transportation, blocking access to health services. This also created a challenge in terms of logistics as medication could not reach health facilities. Overall, the functional access of the population to health services was disturbed.

Prudence also described the public health challenges that affected the health system, further exacerbating the already compromised system. A classic example was the 2008 cholera outbreak, which shook the health system. Other examples given were Measles and Typhoid, that spread in Harare, Zimbabwe. She explained how such insults overwhelmed the health system due to the overconsumption of resources, both material and human.

As explained by Connie, the period after the introduction of reforms, specifically ESAP, resulted in the retrenchment of experienced nurses, causing chaos within the system. There were staff shortages due to a significant gap that was created when nurses in the City Health Department who were older than 60 years were sent home. The population's trust in the overall health system dwindled, and this created a space in which spiritual faith healers resurged as they took advantage of the poor health system. This became a viable alternative for patients who did not receive adequate care from hospitals, and who did not have money to pay health bills in the struggling economy.

Connie went on to discuss the unaffordability of health services which she believed came after health system reforms were introduced. The implementation of ESAP shifted focus from equity to cost recovery and efficiency, leading to the introduction of user fees in line with the aims of ESAP. The result was unaffordability of health care within the general population (Makate 2017:12), with which Connie agreed. Tendai supported this notion and described cost-recovery policies that were introduced into the health system. He explained how health services became an out-of-pocket expense which was unaffordable for its users. He gave an example of how the system moved from providing adequate blood – for free – to a situation where patients had to pay out-of-pocket for every unit of blood received, and the supplies were very low.

Out-of-pocket expenditure is one of the primary reasons why patients forgo health care. Evidence from one study showed that there are inequalities in the utilisation of inpatient health services. Hospitals charge user fees which act as a financial barrier to accessing inpatient care for the poor, hence their utilisation is to a much lesser extent in

comparison to the rich. However, findings from the study showed that the poor tend to use slightly more outpatient care as they rely on PHC facilities. Conversely, the rich can afford high hospital treatment costs, therefore, there was greater hospital utilisation (Zeng et al 2018:300-312). A steady decline in the economic environment of Zimbabwe worsened the levels of poverty, and inequalities still exist. The total consumption poverty line stood at 72% in 2003 (Ministry of Health and Child Welfare 2009:1).

As Tendai mentioned, various basic health campaigns were introduced as part of health system reforms. He said:

> *There was a lot of activity especially within rural areas after introduction of these health campaigns which was good while they lasted.* (Tendai)

James' concern was related to the remuneration of health professionals which was affected by the introduction of ESAP; it meant a decline in budget allocations and cuts in public expenditure. The result has been a health system that is underfunded and does not meet the required 15% of the allocated budget, negatively impacting on salaries and incentives for health personnel. James commented:

> *No policies have been put in place since ESAP to review the remuneration packages for health personnel. This has resulted in industrial actions year in year out with no lasting resolution.* (James)

Musa briefly described how the management structure changed from a pro-medical system, in which medical superintendents oversaw the activities of a public institution, to a business model. According to the participant, the change in the management model did not meet its mission of providing "efficient, effective and responsive health service delivery system" (Health Service Board 2018). He mentioned:

> *There has been no change in service delivery due to government controls.* (Musa)

A key aspect of governance within a health system is taking the opinion of health professionals about their work environment and the public policies that regulate how they work into account (Ortiz-Prado, Fors, Henriquez-Trujillo, Cevallos-Sierra, Barreto-

Grimaldos, Simbaña-Rivera et al 2019:2). A study was conducted in Ecuador, which assessed physicians' perceptions of the performance of the health system and their work environment. The aim of the study was to gain an understanding of the dynamics of the complex health system from the perspective of health professionals. Much like other countries, decisions on public health issues in Ecuador respond to the different political views of the reigning government. The conclusions from the study showed a disconnect between the management and service delivery branches of health care. Reforms undertaken by the government were poorly structured and presented to health professionals; hence, the lack of motivation and buy-in from the health personnel to tackle the deficiencies in the system (Ortiz-Prado et al 2019:12).

On analysis, the researcher identified that participants with higher posts within their departments had more information to give. The other participants were more informed of changes within the departments in which they operated, and not necessarily how these tied in with the bigger picture within the health system. However, some of the changes mirrored the effects of the introduced health system reforms as discussed in literature.

4.3.2.3 Theme 3: The current health system

A strong health system is essential for implementing any health strategies aimed at reducing morbidity and mortality (WHO 2016:13). According to the Constitution of Zimbabwe, the state is committed to "take all practical measures to ensure the provision of basic, accessible and adequate health services throughout the country" (WHO 2016:4). However, as previously mentioned, Zimbabwe has experienced two decades of poor economic performance which has weakened all the pillars of a functional health system (WHO 2016:13). An analysis of the health situation conducted by the WHO – based on key national reference documents and country intelligence – showed the main health achievements and challenges.

This study sought to understand the thoughts, concerns and deliberations on the current state of health care provision as described by participants. Participants were asked to describe the current state of health care in Zimbabwe, providing examples where possible. The literature review in Chapter 2 showed how health reforms had affected the system both negatively and positively, and it was likely for participants to consider how

some of the reforms have influenced the current health system. The unanimous response from participants' narratives was a challenged health system that has progressively gone down.

4.3.2.3.1 Subtheme 3.1: Shortcomings of the current health system

The successful provision of health services is dependent on adequate resources and an appropriate enabling environment. Both these factors have been compromised in the case of Zimbabwe's health system. Studies carried out in several parts of the country have shown inadequacies in the health system building blocks in terms of human resources, medical products, vaccines and technology, health financing, health information, service delivery and leadership and governance.

Public health institutions within the country have been grossly underutilised due to a non-functional health system. Several factors are contributing to this problem:

- Unacceptable vacancy levels for public sector human resources due to the massive exodus of skilled and experienced health professionals, low salaries, and lack of incentives to work in remote areas.
- Weakened and inadequate health management and leadership, which has impacted supervision and monitoring, as evidenced by the deteriorating quality of service provision.
- Health professionals are unable to provide services without adequate medicines and equipment. Stock availability ranges between 29% and 58% for vital items, when it should always be available.
- Dilapidated infrastructure for the delivery of health services. Equipment that is essential for diagnosis and treatment is old, non-functional and outdated. Other physical health infrastructure is in serious disrepair and, as such, most public health institutions cannot meet basic hospital standards for patient care (Ministry of Health and Child Welfare 2009:4-7).
- The health system is grossly underfunded. Zimbabwe's health system is largely financed by the government. However, current funding for health care still falls short of WHO recommendations of US$86 per capita, and misses the 15% Abuja target (WHO 2016:15). The present health system is therefore heavily dependent on external support for essential medicines and the retention of health

professionals. This scenario culminates into some of the challenges that have hit the health system and are described in this theme by study participants.

The narratives below point to some of the challenges that the public health system has been and is experiencing, according to the National Health Strategy. According to Musa, the current health system is plagued by several problems. Firstly, there has been a shortage of medication from NatPharm, the national pharmaceutical company that supplies medication to public institutions. Secondly, there is a collapse in the zoning system, which ensures patients are treated at their nearest health facility. Since the collapse of the zoning system, this has put pressure on public institutions, especially central hospitals like Parirenyatwa; patients visit health institutions they feel will attend to their health needs. The number of people seeking public health services has increased while the economy has been unfavourable to the general population. Patients who can no longer afford private health services have resorted to using public health services, which may be deemed affordable despite the many challenges the public institutions are facing.

Tendai also commented on the issue of a lack of resources within hospitals. He said:

> *Patients have often been asked to bring their own supplies such as surgical items and medication…there was a time when mothers at Mbuya Nehanda maternity wards were detained in the hospital until they had settled their bills.* (Tendai)

Connie weighed in and added:

> *Patients have not been receiving care from public health institutions as they cannot afford it. They do not have money to pay their health bills and have had to opt for alternatives such as traditional medicine.* (Connie)

The outsourcing of certain elements of health services by patients themselves adds to the financial burden. Consequently, seeking health services becomes unaffordable to patients at some point.

The current economic situation has rendered most households in a state of poverty, resulting in poor access to health services. Connie explained how the 2008 cholera outbreak quickly spread to epidemic levels because infected patients could not access much-needed health services. James also referred to the 2008 cholera outbreak, and how it clearly showed the inefficiencies of the health system in managing infectious diseases. To date, the health system is failing to contain diarrhoeal diseases such as cholera and typhoid, although there may be other interlinking factors outside of the health system, such as water supply and sanitation, contributing to the spread of infections.

In 2010, according to Musa, the government froze all vacant posts and recruitment of staff within the health sector. Salaries thus stagnated, and there was low morale among staff, which led to decreased productivity. There have also been numerous strikes that have often plagued the health system as a result of unhappy staff, as explained by Musa:

> *Currently there is general disgruntlement within the public service regarding salaries resulting in strikes every year and this has worsened over the years.* (Musa)

The current socio-economic state of the country has demotivated staff, affecting health professionals' performance at work. James acknowledged the efforts made by the MoHCC to increase training of medical doctors and other key staff within public institutions. However, he went on to explain one of the dire effects of the 'brain drain', which still needs to be addressed. According to supporting literature, health professionals decided to migrate to other countries in search of better remuneration and working environments, leaving a gap within the public health sector. This came as a result of changes in financing as part of the health system reform under ESAP, neglecting the staff at different health institutions as key resources. The state lost qualified personnel, increasing the number of unregistered practitioners to fill in (Muvunzi 2015:6).

Moreover, there is a nationwide shortage of specialist doctors on all levels of health institutions; that is, district, provincial and central hospitals, as described by James. A shortage of specialist doctors means health institutions are now in the hands of junior

doctors, without mentorship from experienced seniors. This places significant risk on the quality of health care being provided. The referral system has also been compromised as a result of the shortage of doctors. Only a few specialist doctors are left within the country and they cannot service all the hospital levels in the country. This has created a situation where most patients are referred to central hospitals where they might receive the required specialised health services. However, the central hospitals are not well equipped for these referrals, compromising the provision of quality health care.

The discussion above shows that Zimbabwe's health system is not performing well enough to address the country's disease burden, hence necessary health reforms should be considered.

4.3.2.3.2 Subtheme 3.2: Strengths of the current health system

The WHO acknowledged Zimbabwe's progress in achieving some of the Millennium Development Goals (MDGs), according to reports by the Zimbabwe Demographic Health Survey (ZDHS) and the Multiple Indicator Cluster Survey (MICs) (WHO 2016:7). Also, despite the country's challenges, Connie believed that the health system is in no worse state compared to the 1990s. She commented:

> *Zimbabwe is doing well in major health indicators although there is much room for improvement…there has been a decline in HIV/AIDS, an improvement in Prevention of Mother to Child Transmission (PMTCT), and improved management of Tuberculosis (TB) and Malaria.* (Connie)

The WHO (2018b) supports Connie's claims that health indicators have improved. Within the period 1980 and 1990, there was a significant decrease in infant mortality from 100 to 50 deaths per 1000 live births (Makate 2017:11). The 2017 infant mortality rate was 22.4 deaths per 1000 live births (WHO 2018b). According to Makate (2017:10), UNICEF (2015) and the WHO (2015), official mortality estimates revealed under-five deaths to be 71 per 1000 live births, nearly two times the overall target for the sub-Saharan region. The WHO (2018b) estimate further found that the under-five mortality rate declined to 50.3 deaths per 1000 live births in 2017, which is a step in the right direction.

The maternal mortality rate increased from 238 to 1068 per 100 000 deaths in 1994 and 2002, respectively (Muvunzi 2015:6). Official 2015 statistics denote a marked decrease in the maternal mortality rate to 443 deaths per 100 000 live births (WHO 2018b). James, in his analysis, mentioned a maternal mortality rate of 600 deaths per 100 000 live births. While the WHO reports indicate this figure showed a decline in the maternal mortality rate from the 2000s, James found the figure concerning and pointed to the need for greater efforts to lower the rate.

A nationwide Tuberculosis (TB) Prevalence Survey was done in 2014, and a prevalence of 292 cases per 100 000 population was reported. Although Zimbabwe remains one of the 30 countries with the highest burden of TB, TB-HIV and drug resistant TB, there has been a steady decline in prevalence. Case notification had declined from 43 000 in 2010 to 29 600 in 2014. A treatment success rate of 81% was also reported for notified TB cases, although it falls short of the 95% target. Moreover, there was a discernible improvement in the detection of Multi-Drug Resistant (MDR) TB from 40 cases in 2012 to 413 in 2014, and 92% of these patients were enrolled in treatment (WHO 2016:10).

The WHO (2016:11) agrees with Connie's views that there has been an improvement in the management of malaria. The incidence of malaria has declined from 58 to 39 per 1000 population from 2009 to 2014, meeting the Abuja target of a malaria incidence rate of 68 per 1000 people. However, amidst all these feats, further research is required to combat the challenge in case management for the age group above five years, as there was no corresponding decline in mortality (WHO 2016:11).

James also acknowledged improvements in the health system and noted:

> *The prevalence and incidence of HIV/AIDS has greatly gone down. However, the current situation within the health system in which there is a lack of drugs may reverse these gains…Zimbabwe has done well in preventative health services such as child immunisation.* (James)

Statistics show a gradual decline in HIV prevalence among adults aged 15 and 49 years as follows; 29.7% in 1997, 18.1% in 2006 and 16.7% in 2014. However, the need to improve the prevalence rate remains as it is still unacceptably high. The country has made impressive progress in terms of the number of people living with HIV with access

to Anti-Retroviral Therapy (ART); the coverage of ART as of December 2015 was 61% for adults and 44% for children (WHO 2016:9).

As explored earlier, some participants showed concern over high vacancy rates and retrenchment of workers. Musa explained the efforts made by the government to replace critical staff, such as doctors, within the system. The Zimbabwean government partnered with Cuban physicians and deployed them into the Zimbabwean health system to fill vacant posts and ease the burden on public institutions (Kidia 2018:2). Fairly strong and improved training programmes have also been put in place for nurses and doctors, bonding newly trained health workers to public institutions. Rudo commented that nursing education had been modified to suit Zimbabwe's current public health needs.

Prudence believed that health provision remains a challenge in Zimbabwe, although all hope is not lost. According to her analysis, she observed:

> *There has been an erosion of key deliverables of health service provision due to the economic, political and social challenges…the health system is striving to head back to where it started in 1980 where primary health care was the premise on which the health system stood on. There have been huge gaps in the system and it almost fell but it is on its way up although not yet fully recovered. The Ministry of Health and Child Welfare is therefore seeking to strengthen primary health care with a goal to achieving universal health coverage.* (Prudence)

Although the current state of the health system presents a gloomy picture, the remaining health professionals continued to provide limited services to the best of their abilities and skill. The combined effort of the government and some health development partners has yielded positive results (Ministry of Health and Child Welfare 2009:6).

4.4 OVERVIEW OF RESEARCH FINDINGS

The chapter presented the findings of the study. The themes that emerged from the study related to (1) Health care provision; (2) Understanding health system reforms; and (3) The current health system. These three themes assisted the researcher in exploring the perceptions of health professionals towards health system reforms and health

provision in Zimbabwe. The findings revealed that the health system went from an efficient to a poor and struggling system. Health professionals in Zimbabwe accumulated different experiences and challenges over the past 20 years in offering health care services, particularly within the public sector.

The study revealed the health professionals' understanding of health system reforms and how these have affected their work environment. The health system before the introduction of reforms was characterised by increased geographical access due to the establishment of new health facilities, improved health indicators such as infant mortality rates, and the introduction of an exemption policy which allowed free health care to the majority of the population. There was further decentralisation of health services to bring the government to the people, and change the management structure within hospitals.

The findings of the study showed that the introduction of health system reforms ushered in changes such as a decline in health indicators, unaffordable health services due to the introduction of user fees, and tightening of the economic environment. Over the years, the health system suffered high staff turnover due to reduced salaries and incentives as a result of cuts in public expenditure. This led to demotivated staff engaging in yearly strikes and, consequently, poor provision of quality health services.

Participants expressed concern over the current health system. The challenges remain and have made the provision of quality health care difficult. Amidst the challenges, some participants remained hopeful that the health system is headed in the right direction.

4.5 CONCLUSION

This chapter presented the results of the study, followed by a discussion thereof. The study aimed to explore and describe the perceptions of health professionals of the changes brought about by health system reforms to create awareness about the concern for health care provision in Zimbabwe.

Participants' demographic data were presented first. This was followed by a presentation and analysis of the research findings. The main findings of the investigation were summarised in each section. The three main themes and subthemes

that emerged from the study assisted in categorising the perceptions of health professionals in Zimbabwe in terms of health system reforms and the changes they brought about.

The findings revealed that health professionals are aware of the functioning of the health system in Zimbabwe and the changes it has undergone over the past 20 years. The study further reflected that health professionals had been challenged to provide quality health care in a deteriorating health system due to several factors. Health system reforms have influenced the current health system both negatively and positively. The performance of the current health system necessitates consideration of other health system reforms to relieve the growing burden on the system. However, it is not all negative as there have been combined efforts from different health partners to provide health services to the best of their abilities, which has produced positive outcomes.

The next chapter concludes the study. The summary and interpretation of the main findings are presented, along with the recommendations, contributions, limitations and overall conclusions of the study.

CHAPTER 5

SUMMARY, RECOMMENDATIONS, CONTRIBUTIONS, LIMITATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This chapter provides a summary and interpretation of the main findings from the study on the perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe. Recommendations from the study are included, along with a discussion on the contributions of the study to the body of knowledge. Conclusions are made based on the purpose of the study, research questions and analysed data. The chapter closes with limitations and concluding remarks related to the study.

5.2 OVERVIEW OF THE STUDY

The focus of this study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe. Since Zimbabwe gained independence in 1980, the country has had a number of economic reforms that have directly or indirectly affected the health system, subsequently impacting the quality of health care provision.

The background and literature review of this study was done by studying global health care reforms, within the African region and in the Zimbabwean setting. The background on the research problem covers the Zimbabwean health system in the three periods: first decade post-independence (1981-1989), second decade in which SAPs were in place (1990-1999), and the economic meltdown, together with the introduction of other economic reforms (2000-to date). Accordingly, the study found that in all these different time periods, there have been significant changes within the health system that have affected the provision of quality care.

The research approach used to achieve the objectives of the study was a qualitative, explorative and descriptive study design. Permission to conduct the study was sought

from the two hospitals under study (see Annexure B). The researcher was granted permission by the Acting Chief Executive Officer at Parirenyatwa Hospital and the Research Ethics Committee at Harare Central Hospital to access the targeted population (see Annexure C). The research population consisted of health professionals who were 40 years of age or older at the time of data collection, and they had worked at either hospital for 20 years or longer. The sampling method used to select and invite potential study participants was purposive sampling as the researcher believed the most critical information to answer the research questions could be obtained from this sample. Ten participants were selected for this study.

A semi-structured pre-tested interview guide was used to conduct face-to-face interviews with participants (see Annexure D). The interviews were conducted in English, were audio-recorded, transcribed and coded according to themes, which were then analysed. The findings were presented and discussed in Chapter 4.

The findings and recommendations described below are centred on the perceptions of ten participants, the research question, the objectives and the themes emerging from the data analysis.

5.3 SUMMARY OF THE RESEARCH FINDINGS

The findings of this study revealed that the majority of participants were between the ages of 40-49 years. Most had spent between 20-30 years at either Parirenyatwa Hospital or Harare Central Hospital. With increasing number of years of experience within the health system, there is a greater likelihood that the participants were well informed about Zimbabwe's health reforms. Hence the study was mostly made up of participants that were deemed to be rich in information relevant to the study. Also, the majority (60%) of participants were nurses. This could be because the number of nurses compared to all other health professionals at any health institution is considerable, therefore increasing the likelihood of them fitting the sample criteria.

While the sample's professional specialities, qualifications, rank and age varied with each individual, common themes emerged with regards to the perceptions of health professionals. Three themes, consisting of five subthemes, arose from the data. The

findings of this study were discussed according to these themes and subthemes as follows:

- Theme 1: Health care provision, which explored the participants' experiences
- Theme 2: Understanding health system reforms
  - Subtheme 2.1: Introduction of health system reforms
  - Subtheme 2.2: Health services before the introduction of health system reforms
  - Subtheme 2.3: Health services after the introduction of health system reforms
- Theme 3: The current health system
  - Subtheme 3.1: Shortcomings of the current health system
  - Subtheme 3.2: Benefits of the current health system

5.4 INTERPRETATION OF THE RESULTS

5.4.1 Theme 1: Health care provision

The findings of this research revealed that all participants were concerned with the state of health care in Zimbabwe and their participation in providing quality health services. The research findings indicated that public health institutions have suffered under the current economic situation, which has caused a countrywide shortage of resources. The health professionals raised concerns over the shortage of medication and medical equipment. They also referred to the shortage of medical staff. All these issues left participants concerned over the provision of quality health care under such circumstances.

A majority of participants, especially nurses, were concerned with the attitudes of health professionals amidst all the challenges facing the health system, which compromise their productivity and quality care. The current economic situation has forced an increasing number of patients to seek public health services regardless of the shortages described, burdening an already compromised health system. Although the health system has done well in improving health indicators such as the maternal mortality rate, infant mortality rate and under-five mortality rate, more efforts need to be made to ensure the numbers are acceptable according to world standards. Such efforts may include include collaboration with the private sector so as to fill some of the gaps in the

health system thus strengthening the structures already in place. The health workforce also needs strengthening as part of the effort to improve health indicators. This can be done through encouraging retention of current workers as well as those that have left the system due to brain drain, motivation of current staff compliment by providing a stmulating, better and safer work environments.

The unanimous response from the participants was that the health system is progressively going down, resulting in deteriorating health care quality.

5.4.2 Theme 2: Understanding health system reforms

The findings of this research revealed that the majority of participants had a good understanding of health system reforms that have been introduced and how they have changed the delivery of health care in Zimbabwe. The findings indicated that interviewed health professionals understood health system reforms regardless of their rank within the different institutions. They each identified several reforms that have been introduced into the health system. ESAP was regarded as the health system reform with the most direct impact on the provision of health services; some of the results have lasted to date. Participants acknowledged that different health system reforms had changed the way health services are delivered and the general quality of health care provision.

5.4.3 Theme 3: The current health system

It was determined that the current health system is experiencing both shortcomings and strengths. The majority of participants agreed that the current health system is challenged.

The current health system is poorly performing and is primarily plagued by inadequate resources such as medication, infrastructure, health financing and health professionals. There is also poor access to health services due to a state of poverty within households, thus patients cannot afford health care. The provision of quality health care has been compromised by low morale and motivation among staff due to poor working conditions and stagnated salaries.

It was determined that the premise on which the current Zimbabwean health system was found still stands. The combined effort of the government and health professionals has led to improved health indicators, such as the infant mortality rate and maternal mortality rate. Tuberculosis and HIV prevalence also steadily declined over the years, and there has been an improvement in the management of malaria. With such information regarding the current health system's strengths and shortcomings, health professionals can take up positions of influence and change within the system. Which ever way the health professionals deem the current health system to be in should be considered with utmost care as it is first hand experience and most likely they would know how to improve or strengthen the system so it can deliver on its promises and standards.

The purpose of the study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe. The study did shed light and insight on the experiences of health professionals with the health system over the years with particular interest in changes brought about by health system reforms. The findings from the study have enabled recommendations which could be made to improve health system reforms and how they affect provision of health care as well as making aware any concerns related to health care provision.

It should be noted that this study aimed to answer the following research questions and objectives:

- What is health professionals' understanding of health system reforms that have occurred in Zimbabwe?
- What are the health professionals' perceptions of the changes brought about by health system reforms in Zimbabwe?

By answering these questions, the study achieved the following two objectives:

- To explore and describe the perceptions of health professionals on the changes brought about by health system reforms in the public health sector.
- To identify the concerns of health professionals in providing health care in Zimbabwe.

Objective 1 was presented in Sections 4.3.2.1 and 4.3.2.2, and Objective 2 was presented in Section 4.3.2.3. The researcher is of the view that the study objectives were met.

5.5 RECOMMENDATIONS

This study proposes a few recommendations regarding health system reforms and further research to be done on this topic. Health professionals occupy positions where they notice the impact of different policies within the health system. Therefore, policymaking and health system reforms should include health professionals from top-down as they form part of the structures in the delivery of quality health services. Any information on changes in policy or health system reforms should be properly and timely disseminated. Such information should be broken down to how it will affect the overall health system and the delivery of health services as a whole, all the way to individual departments.

Further research on the topic should also be conducted with a larger, more diverse group of health professionals to give more insight into the effects of health system reforms within different departments in the health sector. Other public health institutions, as well as clinics around Zimbabwe, should be included in further research, which could then be compared with the findings from this study.

5.6 CONTRIBUTIONS OF THE STUDY

The expected contributions of this study can be divided into policy enhancement and additional knowledge for further scholarly research. The findings from this study may be used by policymakers to inform decision making regarding health provision in future health reforms. The introduction of macro-economic reforms creates significant changes in other social sectors, including the health sector, resulting in health care reforms which affect health care provision. It is therefore important to study changes brought about by reforms introduced into the health system without neglecting health professionals, who are part of the actors involved in policy reforms. The findings of this study will thus be helpful in creating awareness for future interventions in cases of introducing health reforms.

5.7 LIMITATIONS OF THE STUDY

This study only focused on the perceptions of health professionals at Parirenyatwa and Harare Central Hospital, and the researcher does not claim that the findings can be generalised to other health professionals in other areas. Any research conducted on this topic in other health institutions might yield different results.

The ease of finding participants that fit the inclusion criteria posed a limitation as some health professionals who might have had knowledge on the topic had migrated to other countries or shifted to the private sector. This made the pool of potential participants quite small.

The researcher claims that qualitative research was the right choice for this study. However, qualitative research tools, such as interviews, are not designed to capture hard facts. A survey designed for quantitative research might offer more evidence to strengthen the data uncovered in this study using qualitative research tools.

Although the researcher took all efforts to avoid interruptions, the setting for the interviews was found to have interferences. Interviews took place in a designated quiet room at each hospital. However, there were interferences from ringing phones and knocking on the door from colleagues who were not aware that an interview was in progress.

The process of data collection through interviews was also time-consuming for the researcher. The researcher was the sole data collection instrument for the semi-structured interviews and analysis, hence there was the potential of bias. However, the possibility of bias was minimised through strategies such as trustworthiness being applied throughout the study.

5.8 CONCLUDING REMARKS

The purpose of this study was to explore and describe the perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe. The study found that health professionals had an understanding of health system

reforms. The health professionals felt that the introduced health system reforms have led to changes within the health system impacting on the provision of quality health services. Other professionals were not fully informed about how health system reforms have impacted the health system and the changes it has created. There is a need for health professionals to keep abreast with issues that affect the environment in which they practice for the efficient and continuous provision of quality health care.

The study will have reached its objectives if the findings contribute to an understanding of the perceptions of health professionals on health system reforms; not only in Zimbabwe but in other countries with similar settings. The recommendations emerging from the study can serve as a basis for future research. The researcher is of the view that the study will have reached its goal if the findings caution policymakers to consider the implications of agreements reached at political level on ordinary people. In light of the above, the findings will be shared in the hope that they inform future decisions when introducing health system reforms.

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ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE FROM THE DEPARTMENT OF HEALTH STUDIES, UNISA

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

4 July 2018

Dear Miss Charlene Rudo Deve

Decision: Ethics Approval

HSHDC/864/2018

Student: Miss Charlene Rudo Deve

Student No.:61948705
Supervisor: Prof RMM Mmusi-Phetoe
Qualification: PhD
Joint Supervisor: -

Name: Miss Charlene Rudo Deve

Proposal: Perceptions of health professionals on the changes brought about by health systems reforms in Zimbabwe

Qualification: **MPCHS94**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 4 July 2018 to 4 July 2020

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on. 4 July 2018

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *You are required to submit an annual report by 30 January of each year that that he study is active. Reports should be submitted to the administrator HSREC@unisa.ac..az Should the reports not be forthcoming the ethical permission might be revoked until such time as the reports are presented.*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

pp

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof A Phillips
DEAN OF COLLEGE OF HUMAN SCIENCES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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ANNEXURE B: LETTER SEEKING PERMISSION FROM HARARE CENTRAL HOSPITAL AND PARIRENYATWA HOSPITAL

07 August 2019

TO: The Chief Executive Officer
ATTENTION: Harare Central Hospital Ethics Committee
Harare Central Hospital
Harare

PERMISSION TO CONDUCT RESEARCH STUDY AT HARARE CENTRAL HOSPITAL

My name is Charlene R Deve and I am currently enrolled as a Master of Public Health (MPH) student at University of South Africa (UNISA) in Pretoria. My study is on the "Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe" and this requires me to collect data from health professionals who have worked in the public health sector for 20 years or more. This will be qualitative research, conducted under the supervision of Prof RM Mmusi-Phetoe (UNISA, South Africa).

I am hereby seeking permission to conduct in-depth face to face interviews with healthcare professionals specifically doctors, nurses, pharmacists as well as the administrative staff. I have included a copy of the approval letter which I received from the Health Studies Research AND Ethics Committee (Chairperson: Prof JE Maritz, Email: maritje@unisa.ac.za).

Upon completion of the study, I will acknowledge your contribution to my thesis. Please do not hesitate to contact me for any further information on my mobile numbers: +263 (0) 77 3560560 or email: 61948705@mylifeunisa.ac.za / charlenerdeve@gmail.com .

If you do agree kindly sign below together with the hospital stamp or alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging permission to conduct this study at your institution.

Yours sincerely

Charlene Deve

Master of Public Health, Department of Health Studies, UNISA

Approved by _____

(print your name and title here)

Signature _____

Date _____

08 July 2019

TO: The Chief Executive Officer
ATTENTION: Director of Operations
Parirenyatwa Hospital
Harare

RE: PERMISSION TO CONDUCT RESEARCH STUDY AT PARIRENYATWA HOSPITAL

My name is Charlene R. Deve and I am currently enrolled as a Master of Public Health (MPH) student at University of South Africa (UNISA) in Pretoria. My study is on the "Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe" and this requires me to collect data from health professionals who have worked in the public health sector for 20years or more. This will be qualitative research, conducted under the supervision of Prof. R.M Mmusi-Phetoe (UNISA, South Africa).

I am hereby seeking permission to conduct in-depth face to face interviews with healthcare professionals specifically doctors, nurses, pharmacists as well as the administrative staff. I have included a copy of the approval letter which I received from the Health Studies Research & Ethics Committee (Chairperson: Prof. JE Maritz, Email: maritje@unisa.ac.za).

Upon completion of the study, I will acknowledge your contribution to my thesis. Please do not hesitate to contact me for any further information on my mobile numbers: +263 (0) 77 3560560 or email: 61948705@mylifeunisa.ac.za / charlenerdeve@gmail.com .

If you do agree kindly sign below together with the hospital stamp or alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging permission to conduct this study at your institution.

Yours Sincerely,

Charlene Deve

Master of Public Health, Department of Health Studies, UNISA

Approved by_____

(print your name and title here)

Signature _____

Date _____

ANNEXURE C: APPROVAL LETTERS FROM HARARE CENTRAL HOSPITAL AND PARIRENYATWA HOSPITAL

Telephone: 621100-19
Fax: 621157

Reference: HCHEC 280819/48

HARARE CENTRAL HOSPITAL
P. O. Box ST 14

SOUTHERTON

ZIMBABWE

Harare

03 September 2019

Miss. R. Charlene Deve
15 Lindrick Road
Ashdon Park
HARARE

Dear Miss. Charlene,

REF: PERCEPTIONS OF HEALTH PROFESSIONALS ON THE CHANGES BROUGHT ABOUT BY HEALTH SYSTEMS REFORMS IN ZIMBABWE

I am glad to advise you that your application to conduct a study entitled: **Perceptions of Health Professionals on the Changes Brought about by Health Systems Reforms in Zimbabwe (Ref: HCHEC 280819/48),** has been Approved by the Harare Hospital Ethics Committee.

This approval is premised on the submitted protocol. Should you decide to vary your protocol in any material way please submit these for further approval.

You are advised to avail the results of your study whether positive or negative to the hospital through the committee for our information.

Yours sincerely,

H ARE CENTRAL HOSPITAL
DEPARTM T OF MEDICINE
0 3 P 2019
P. O. BOX ST14 SOUTHERTON

DR. C. Pasi
Chairman Harare Central Hospital Ethics Committee

Board Members, Chairman Dr E Chagonda, uty rperson , em :- Mr J Makiya, Mrs P Sibanda, Mr. S. Hlatywayo, Dr A Mahomva and Dr T. Dobbie (Chief Executive Officer)

08 July 2019

TO: The Chief Executive Officer
ATTENTION: Director of Operations
Parirenyatwa Hospital
Harare

RE: PERMISSION TO CONDUCT RESEARCH STUDY AT PARIRENYATWA HOSPITAL

My name is Charlene R. Deve and I am currently enrolled as a Master of Public Health (MPH) student at University of South Africa (UNISA) in Pretoria. My study is on the "Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe" and this requires me to collect data from health professionals who have worked in the public health sector for 20years or more. This will be qualitative research, conducted under the supervision of Prof. R.M Mmusi-Phetoe (UNISA, South Africa).

I am hereby seeking permission to conduct in-depth face to face interviews with healthcare professionals specifically doctors, nurses, pharmacists as well as the administrative staff. I have included a copy of the approval letter which I received from the Health Studies Research & Ethics Committee (Chairperson: Prof. JE Maritz, Email: maritje@unisa.ac.za).

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If you do agree kindly sign below together with the hospital stamp or alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging permission to conduct this study at your institution.

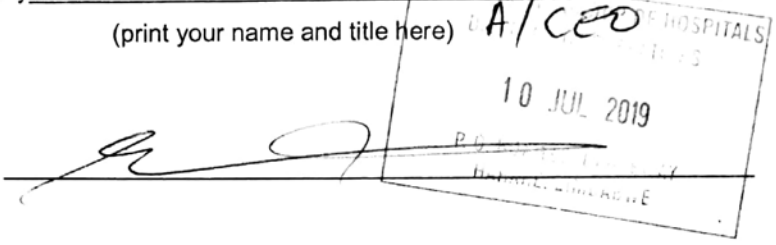
Yours Sincerely,

Charlene Deve

Master of Public Health, Department of Health Studies, UNISA

Approved by MUNDENDA EDSON

(print your name and title here) A/CEO



Signature _____

Date _____

ANNEXURE D: DATA COLLECTION INSTRUMENT

Interview guide: Perceptions of health professionals on the changes brought about by health system's reforms in Zimbabwe.

Section A: Demographic information

1. **Age in years:** ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ 70 or more years.

2. **Qualification:**

3. **Rank/Title of Participant:**

4. **Period in the Hospital (in years):** ☐ 20-30 ☐ 31-40 ☐ above 40

Section B: Research questions

(Ice breaker)

- How many years have you worked within public health institutions and which roles have you assumed over this period?

Grand tour questions

- You say you have been employed for **years as a ***. Please describe for me how you have experienced the delivery of health services over these years
- Tell me about the reforms introduced into the health system since 1990 up to date
- How would you describe the health care provision before the introduction of health system reforms in Zimbabwe?
- How would you describe the healthcare provision after the health system reforms in Zimbabwe?
- How would you describe the current state of healthcare provision in Zimbabwe and if possible give examples?

- From your perspective, how would you describe the changes brought about by the health system reforms you have explained earlier? Would you give specific examples of such changes?
- Are there any other comments you would like to make in regards to the topic we have been discussing?

THANK YOU FOR PARTICIPATING IN THIS STUDY.

ANNEXURE E: CONSENT FORM

Dear research participant

I am Charlene R. Deve, a Masters' in Public Health research student at the University of South Africa (UNISA). As part of the requirements for my Master's Degree I have to complete a research dissertation. The title of the research is: Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe. If you agree to participate in this study, the researcher will conduct a face-to-face interview with you. Please understand that **your participation is voluntary.** This means that you will not be forced to take part in this study. The choice of whether to participate is yours alone. However, without your kind co-operation, I will not be able to find information required for this project work.

The study will be conducted through a face to face in depth interview with the researcher who will use an interview guide. Please note that there are no right or wrong answers and you are not obliged to answer all the questions asked. The interview will last approximately 30 minutes.

At all times, I shall keep your details safe and treat all information given to me as confidential. Your actual name or identity will not be known to anyone else related to the research. You are free to withdraw without any penalty. There are no anticipated risks, compensation or other direct benefits to you as a participant in this study. If you have any questions about this research protocol, please contact me at 61948705@mylifeunisa.ac.za or +263 (0) 77 3560560.

Please Initial Box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

June 07, 2018

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐

3. I agree to take part in the above study. ☐

4. I agree to the interview being voice-recorded ☐

Please sign and return this copy of the form as permission to report your responses in the final manuscript to be submitted to my supervisors.

[Name]_____

_____ _____

Signature of participant Date

ANNEXURE F: CONFIDENTIALITY BINDING FORM

Study title: Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe

Date……

Names:

Participant……Researcher…….....

Type of business:

This is a study being undertaken by a Master of Public Health student who is studying with the University of South Africa (UNISA).

Reason for disclosure

Information collected from this interview will be kept in confidence. Besides the researcher the only other persons who may access the information if need arises are a transcriber, research supervisors and examiners from UNISA.

Information to be protected

The information gathered will relate to the health system reforms that have been introduced since the 90s and exploring the perceptions of health professionals on the changes brought about by these reforms.

Signatures:

Participant……

Researcher……..

Transcriber……

ANNEXURE G: LANGUAGE EDITING CERTIFICATE

Between the lines editing

Leatitia Romero
Professional Copy Editor, Translator and Proofreader
(BA HONS)

Cell: 083 236 4536
leatitiaromero@gmail.com
www.betweenthelinesediting.co.za

25 June 2020

To whom it may concern:

I hereby confirm that I have edited the dissertation entitled: "PERCEPTIONS OF HEALTH PROFESSIONALS ON THE CHANGES BROUGHT ABOUT BY HEALTH SYSTEM REFORMS IN ZIMBABWE". Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work.

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001)
EASA: English Academy of South Africa
SATI: South African Translators' Institute (1003002)
SfEP: Society for Editors and Proofreaders (15687)
REASA: Research Ethics Committee Association of Southern Africa (104)

ANNEXURE H: TURNITIN ORIGINALITY REPORT

Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe

by Charlene Rudo Deve

Submission date: 16-Jul-2020 05:29PM (UTC+0200)
Submission ID: 1358246099
File name: Charlene_Rudo_Deve_final_8_July_2020_1.docx (3.61M)
Word count: 27521
Character count: 160845

Perceptions of health professionals on the changes brought about by health system reforms in Zimbabwe

ORIGINALITY REPORT

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3	Celalettin Cevik, Kaan Sozmen, Bulent Kilic. "How primary care reforms influenced health indicators in Manisa district in Turkey: Lessons for general practitioners", European Journal of General Practice, 2017 Publication	1%

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