The impact of promoting stakeholder participation to improve Primary Health Care: A Case of Dangamvura Township Ward 7 & 15, Mutare, Zimbabwe

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DECLARATION

I hereby declare that this dissertation is the result of my work, except where otherwise indicated and due acknowledgement is given.

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Michelle R. Tsonga (student) Date

____

Dr Sihle Moon (Supervisor) Date

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DEDICATION

I dedicate this work to my father, Mr S.P. Tsonga and mother, Mrs E. Tsonga, who with lots of love supported me throughout this journey. Despite all the challenges I faced they encouraged me to work harder. I also dedicate my work to my husband, Paddington Nyabadza and my son Ethan Atipa Panashe Nyabadza. My beloved spouse also gave me the courage and strength to continue with my studies. I love you so much.

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ABSTRACT

Stakeholder participation is an essential component in Primary Health Care as it involves the influence, investment and interest of people who participate in any capacity. In Zimbabwe, PHC has declined due to the economic conditions, shortage of drugs and skilled health professionals. In the case of Dangamvura Township, there is an increasing influx of number of people who are immigrating to live in the location. As a result of this influx the health facilities are now constrained to adequately facilitate and sustain the PHC needs of the residents. This research aimed at exploring if stakeholder participation can have an impact on improving the conditions of PHC. The main question asked was: What is the impact of promoting stakeholder participation in Primary health care in Dangamvura Township?

The current state can be caused by a variety of sources but for this dissertation the focus was on one source of the problem which is Rapid Population Growth (RPG). Primary Health Care in Dangamvura cannot sustain the population growth in the township and therefore causing a lot of problems within the community. The stakeholders within the Primary Health Care, namely the community members, their leaders, doctors and nurses face many challenges in their effort to cope with the poor health conditions. A mixed methods research approach (qualitative and quantitative) guided by the interpretivist or constructivist paradigm was used to conduct the research. The dissertation's main goal was to explore responses to the local health problems and ways to solve these problems through stakeholder participation. The findings revealed, amongst others, that government programmes that were planned without local people's knowledge encountered a plethora of challenges which stifled effective and efficient implementation. Even though the community gatherings were held for health programs, the implementation process was rather long and eventually some ideas were just left redundant. One of the recommendations arising from the study was that the government should address social determinants of health related to poverty and poor living conditions. A further recommendation was that health care policies which are currently implemented should be revised to ensure that all Zimbabweans have access to health care. The implementation of such policies should be monitored and evaluated on a regular basis and in this way service delivery and access of patients to health care facilities will be improved.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
GDP	Gross Domestic Product
MOH	Ministry of Health
MOHCC	Ministry of Health and Child Care
MoHCW	Ministry of Health and Child Welfare
NGOs	Non-Governmental Organisations
PDP	Productive Development Partnerships
PHC	Primary Health Care
PPP	Public Private Partnerships
PSC	Public Service Commission
RPG	Rapid Population Growth
SUS	Sistema Unico de Saude
UN	United Nations
WHO	World Health Organization
ZANU-PF	Zimbabwe African National Union- Patriotic Front
VIDCOs	Village Development Committees
WARDCO	Ward Development Committee
HCC	Health Centre Committees

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Chapter 1: Introduction

1.1 Introduction

In Zimbabwe, cooperation between stakeholders in the management of primary health care has slackened, causing concern about health care growth (Masuka & Ray, 2017). The health sector has declined over the past five years and has affected communities' well - being. Improved involvement of stakeholders could improve the quality of healthcare services that could reduce the mortality rate and increase life expectancy. Wheeler and Sillanpaa (1998) stated that in the development of health strategies, stakeholders such as the medical staff, patients, community leaders and local government should work together to ensure that strategies are well implemented. They argue that listening to the beliefs and needs of stakeholders and responding to them is essential, not only for ethical reasons, but also for the creation of sustainable health policies and better cooperation between organisations (Wheeler & Sillanpaa, 1998). According to Tsiko (2017) a researcher and family physician at the University of Washington, Prof Thompson, told a public lecture at the University of Zimbabwe's College of Health Sciences, that the traditional legacy of curative and hospital-centric approach to health care is simply unsustainable, and that cheaper, effective and readily accessible community oriented primary health care is now the way to go to deal with the health needs of the people.

In Zimbabwe health care stakeholders, such as doctors, the local government, Non-Governmental Organisations (NGOs) and community members, have developed methods in the past 10 years to a resuscitate the health sector that has not been consistently reliable (ZIMFACT, 2018). Poor health service delivery in Zimbabwe is partly caused by the lack of stakeholder participation. In this research, Brazil and Cuba are used as case studies to demonstrate how different stakeholders have participated to ensure a better standard and availability of primary health care in the communities. It also helps recognise how both countries have developed a system that meets their needs and is sufficient to accommodate their health and economic needs. By using

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Brazil and Cuba as examples of stakeholder involvement this will positively help Zimbabwe to adapt some of their health strategies.

1.2 Background of the study

The Zimbabwe government declared a policy of equity in health in 1980. The policy in black and white included explicit assurances to redistribute health resources, respond to health requirements, prevent ill health and integrate community participation (Ministry of Health and Child Welfare (MoHCW),1997). Health investments in the 1980s resulted in significant reductions in morbidity and mortality, reduced differences between urban and rural communities and improved access to preventive and curative health services (Loewenson & Chisvo, 1994). In the 1990s, the combined effects of Acquired Immune Deficiency Syndrome (AIDS), drought, poor economic performance and high levels of poverty led to some of these gains being stagnated or reversed, raising new health challenges against the background of unresolved environmental, reproductive, communicable and non-communicable disease risks (MoHCW, 1997). In the 1990s, reductions in real per capita health budget allocations were linked to declining health workers' incomes and increased pressure on households to finance health needs, despite high poverty levels. These conditions, together with a significant increase in mortality associated with HIV / AIDS have led to protests from different quarters and request for renewed commitment to invest in the nation's health (Mackian, 2000).

A widespread strike of junior doctors and nurses at the end of 1996 crippled public services in central and urban areas for many weeks and highlighted the dissatisfaction in health services (MoHCW, 1997). In the same year, the congress of the Zimbabwe African National Union – Patriotic Front (ZANU–PF) and the National Work Centre (ZCTU) called for a health sector investigation commission. Professionals, civic groups and communities expressed their dissatisfaction with the decline in quality of care, charges imposed, unworkable exemption processes, inadequate supply of drugs, long waiting times, negative attitudes of health workers, transport problems to and between health services and declining health workers' salaries. Professionals in the public sector reported disillusionment with their profession and also noted that falling wages increased the likely abuse of public resources for private gain (Bassett et al., 1997;

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CWGH 1997; Mutizwa-Mangiza, 1997).In 1980, the Ministry of Health was reported as providing 71% of health expenditure (MoHCW ,1984). By 1994, the share of health expenditure in the Ministry of Health had dropped to 29 percent, with 31 percent from individual direct payments, 12.2 percent from donor financing and a total share of health expenditure in the private sector of 48.8 percent. The increasing share of health pocket payments reflects increased expenditure across all income groups, including the poor. Increased health spending has made people more sensitive to the use of their money and the quality of health services (Schedler, 1999).

The PHC approach in Zimbabwe is based on three basic ideas:

- Progress in the state of health is fundamentally dependent on improving socio - economic conditions
- That mass involvement was the key to overcoming these conditions ; and
- That the health care system had to be adapted to the "mass needs of people" through primary health activities. (Ministry of Health, 1984).

Extreme inequality in income, inherited from a century of British colonialism, was evident in Zimbabwe's wide health disparities (Sanders, 1980). The government adopted the Primary Health Care (PHC) approach two years after the Alma Ata Declaration in 1978, directing resources to disadvantaged areas and the active participation of communities in an endeavour to transformation the health sector (Mugwagwa, Chinyadza & Banda, 2017).

Community involvement, from both organised and unorganised public groups, has been widely argued over the past decade as an important factor in improving health outcomes and health systems' performance (Chikwature & Chikwature, 2019). Despite this, and the common inclusion of participation as both means and ends in health policy, participation as a factor in itself is often poorly operationalised and evaluated, both in health systems planning and implementation. In Zimbabwe, participation in the implementation of health actions (prevention, care and information sharing) is perceived to be limited at the moment. Higher - level decisions continue to have weak public input or consultation (Mugwagwa, Chinyadza & Banda, 2017). In this regard, stakeholder participation in improving primary health care is viewed as one of the solutions to accessible primary health care and is seen as one of the

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solutions to address accessible primary health care in communities (Chikwature & Chikwature, 2019).

1.3 Statement of the problem

The ongoing economic decline has led to diminishing budgets available for health care, resulting in reduced provision at all levels (Masuka & Ray, 2017). The near collapse of the health system in 2008 was followed in 2009–2012 by some recovery of the economy and renewed investment in health services. Economic growth declined again during 2013–2017, with 72% of the population now living below the national poverty line and 21% living on less than $1.90 a day (ZIMSTATS, 2017). The local government makes decisions for the community mostly based on their political agenda but not on the needs of the community (Tsiko, 2017). As a result, very few public health institutions can meet basic hospital standards for measures to control patient care and infection (National Health Strategy 2016-2020). Doctors and nurses in Zimbabwe went on a national strike since the beginning of March 2018, protesting against poor remuneration and unsatisfactory working conditions, leading to the closure of almost all central hospitals, children's units, provincial hospitals and the stagnation of emergency lifesaving procedures throughout the country, according to their representative body, the Zimbabwe Hospital Doctors Association (ZHDA) (ZIMFACT, 2018).

Primary health care (PHC) represents both a qualitative and a quantitative change in health care, both improving access to high risk groups, such as women and children, as well as emphasising to a greater degree community involvement and preventive and promote care (Trochim, 2002). Among other problems rapid population growth (RPG) has been seen as a primary cause to these effects of PHC in Zimbabwe for the past decade. It is used to describe an over - population state in terms of existing resource, in this case health resource (Charlot, 2012). Due to different economic, social and political problems or effects, rural to urban migration has been on peak with people looking for better living conditions in cities and areas around towns (Nyoni & Bonga, 2017). Rapid population growth led to the formation of new settlement areas in order to accommodate the population. As though seeming like a good solution, forming and expanding settlements comes with challenges, disappointments and

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flaws. More people are settling in Dangamvura leading to the development and expansion of more informal and formal settlements. It is the largest township in the city of Mutare with a population of about 47 120 (Mutare census, 2012). Dangamvura Township has one polyclinic and 2 private clinics (Dangamvura Polyclinic Annual Report, 2018). Being a high density suburb, it caters for people of all walks of life from the young to the geriatrics, the unemployed, self-employed and the formally employed.

Shortage of skilled professionals, lack of essential drugs and commodities, and the township's polyclinic and private clinic failure to facilitate the entire community have been the evidently seen and experienced by the community (Chikwature & Chikwature, 2019). Old, outdated and non-functional medical equipment is critical for diagnosis and treatment (National Health Strategy 2016 - 2020). With a rapid increasing population, the community becomes vulnerable for diseases caused by poor sanitation and lack of services like water supply. Distance to clinics also determines whether primary health care is going to be accessed. RPG plays a role in the formation of new settlements which will be far away from PHC services provided and also strains the available services (Nyoni & Bonga, 2017). This study explores and analyse the impact of promoting stakeholder participation in Dangamvura Ward 7 & 15's quality of service delivery in primary health care in order to meet the rapid increasing demand of primary health care. The study evaluated how different stakeholders in a rapidly growing community can work together to increase awareness of health care and accessibility.

1.4 Research Objectives

The primary aim of the study was to establish the impact of promoting stakeholder participation in Primary Health Care in Dangamvura Township.

Secondary objectives: The secondary and specific objectives of the study were:

- To investigate the extent of participation and influence of stakeholders in the management of Primary Health Care in the township of Dangamvura.
- To determine the availability and impact of stakeholders' platform for interaction in an endeavour to improve PHC.

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- To explore stakeholders’ perceptions of the quality of service in primary health care.
- To identify strategies to improve participation and involvement of stakeholders in PHC.

1.5 Research Questions

The primary question is: What is the impact of promoting stakeholder participation in Primary health care at Dangamvura Township?

Specific Research Questions

- What is the current position with regard to stakeholder participation and contribution in the management of primary healthcare in Dangamvura?
- Do stakeholders have a platform for interaction to improve PHC?
- What is the stakeholders ' perception of the quality of service in PHC?
- What strategies can be used to improve participation of stakeholders?

1.6 Significance of the Study

A critical understanding of the impact of stakeholder participation on the quality of service provision in primary health care is of great importance in Zimbabwe. Improving the quality of service in primary health care by including stakeholders in decision-making and implementation processes would also contribute to the country's social and economic development. Although the study is specifically done in Dangamvura Township, the findings of the study will help to give insights on the policies which can be implemented to increase stakeholder participation in efforts to increase service delivery that is essential to every Zimbabwean. In the context of Zimbabwe's township areas, knowledge about the influence of socio-economic and institutional factors such as household income, distance from the nearest health facility, fees for consultation and the availability of drugs must be improved. The purpose of this study was to enlighten stakeholders on possible ways of being more active in the governing of healthcare, being accountable and to make informed decisions or give the relevant

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resources were possible. This information will also be used for lobbying and advocacy purposes aimed at influencing change in policies and practices at local, provincial and national government levels.

1.7 Key Definitions

Access (to health services): The ability, or perceived ability, to reach health services or health facilities in terms of location, timeliness, and ease of approach.

Accountability: means having the obligation to answer questions regarding decisions and/or actions (Brinkerhoff, 2003)

Community: "a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with one another. It functions within a particular social structure and exhibits and creates norms, values and social institutions" (WHO, 1974)

Community participation: a social process whereby specific groups, with shared needs living in a defined geographic area, actively pursue identification of their needs, make decisions and establish mechanisms to meet these needs (Rifkin, Muller, F & Bichmann, 1988)

Delivery: defined as the act of delivering or distributing something or carry out or perform, or to rescue: recovery or preservation from loss or danger. In the context of this study, delivery refers to carrying out or performing the services related to primary health care (Ministry of Health, 1984)

Health: State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (WHO, 2018)

Primary Health care: Primary health care is a strategy that seeks to respond justifiably, appropriately, effectively to basic health needs, and to address the underlying economic, social and political causes of poor health; hence providing accessible essential health services and to involve the participation of communities (WHO,2014)

Stakeholders: is a person or group with an interest, involvement or investment in something; people who will be affected by a project, or who can influence it, but who are not directly involved in doing the work (Muller, 1996)

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1.8 Structure of the research

The research comprises six chapters which are briefly discussed below in terms of their contents and purpose.

Chapter 1: Introduction:

This chapter provides the background on primary health care in Zimbabwe. This is followed by the problem statement which states how and why service delivery in primary health care is a problem in Zimbabwe. This chapter also presents objectives of the study and significance of the study. A definition and discussion of the structure of the study conclude this chapter.

Chapter 2: Primary Health Care in Zimbabwe

The literature in this chapter provides a discussion on the nature of PHC, its origin, elements involved, challenges faced and factors to consider for a successful PHC. The chapter later provides information on Zimbabwe PHC. It includes the country's profile, its health care status, referral system and the role of health workers and the government.

Chapter 3: Primary Health Care in Cuba and Brazil

This chapter provides information on stakeholder involvement and accountability in the quality of service provision in Primary Health Care in Brazil and Cuba.

Chapter 4: Methodology

The research design and methodology used for the study are presented in this chapter. Data collection and data analysis are also explained here.

Chapter 5: Findings & discussions

The research findings from individual in-depth interviews, questionnaires and existing data are presented and discussed in this chapter

Chapter 6: Conclusion and Recommendations

This chapter will outline the way forward to ensure Primary Health Care improves and the recommendations that will make the strategies sustainable.

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Chapter 2: Primary Health Care: Brazil and Cuba

2.1 Introduction

This chapter provides a better understanding of the Primary Health Care concept and also displays an ideal structure of what good Primary Health Care should be like. The discussion also provides the different ways to achieve PHC and therefore make it sustainable for the communities. The discussion also provides the different ways to achieve PHC and therefore make it sustainable for the communities by drawing examples from Brazil and Cuba. Since the Alma Ata declaration, countries such as Brazil and Cuba have successfully implemented the PHC approach to deliver health services, whilst others such as Zambia and South Africa continue to battle with challenges that impede progress in this regard. This chapter is connected to this project because stakeholder participation in Brazil and Cuba has resulted in good access to health services. This research intends to analyse the impact of promoting stakeholder participation in the quality of service provision in Primary Health Care in Dangamvura Ward 7 and 15.

2.2 Primary Health Care

In the last 20 years, the concept of primary health care has emerged in response to assessments of community health needs, which showed that large percentages of people lacked access to adequate health care. Primary healthcare has played a central role in the strategy to meet the needs of healthcare in many countries, especially in the developing world, although many industrialised countries are now paying more attention to it (Epp & Vuori and Hastings, 1986; Zakus, 1988). Section V11 of the Declaration of Alma Ata (WHO, 1978: 428-30) describes Primary Health Care as a phenomenon which:

- reflects and develops from the economic conditions and socio - cultural and political characteristics of the country and its communities;
- based on the application of relevant results from research into social, biomedical and health services and experience in public health;

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- addresses the main health problems in the community by providing promotion, preventive, curative and rehabilitative services accordingly;
- Health education and methods of preventing and controlling health problems; support for food supply and proper nutrition; adequate supply of safe water and basic sanitation. Maternal and child health care, including family planning, immunization against major infectious diseases, endemic disease prevention and control, appropriate treatment of common diseases and injuries; and provision of essential drugs;
- involves all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors and demands the co-ordinated efforts of all those sectors; and
- requires and promotes maximum independence from the community and individuals and participation in the planning, organisation, operation and control of PHC, making full use of local and national and other available resources; and develops, through appropriate education, the ability of communities to participate

2.3 The origins of primary health care

During the Cold War (late 1960s and early 1970s) the United States was embroiled in a crisis of its own world hegemony - the concept of primary health care emerged in this political context (Litsios, 2002). The idea of an international conference on primary health care was created by the Chinese delegation to the WHO. The Soviet Union initially opposed the proposal and advocated for a more medical approach for backward countries. However, after noticing that the primary health care movement was growing, the Soviet delegate to the WHO declared in 1974 that his country was eager to hold the meeting (Goldstein & Price, 1995). The WHO has been looking for an alternative site for a while. Iran, Egypt, and Costa Rica's governments entertained the idea, but eventually declined. Finally, the WHO accepted the Soviet offer, but requested a location other than Moscow, suggesting a provincial city. Alma - Ata was selected after some negotiations, partly because of the remarkable improvements in health experienced in what was a backward area during Tsarist Russia. 3,000 delegates from 134 governments and 67 international organisations from around the world attended the conference. The International Conference on Primary Health Care

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took place at Alma-Ata from September 6 to 12, 1978. Alma-Ata was the capital of the Soviet Republic of Kazakhstan, located in the Asiatic region of the Soviet Union (World Health Organisation, 2018)

2.4 Community participation

The World Health Organization (WHO) defines community participation in health, sometimes called consumer involvement, as the process by which members of the community, either individually or collectively, and with varying levels of commitment and action:

- Develop the capability to assume greater responsibility for assessing their health needs and problems.
- Plan, decide and then act to implement their solutions.
- Create and maintain organisations in support of these efforts.
- Evaluate the effects and bring about necessary adjustments in goals, targets and programmes on an ongoing basis (WHO, 1991)

Community participation in health is therefore a process in which the community participates in actions aimed at improving health status. Community participation was forged as a cornerstone of PHC in 1978 in the Declaration of Alma-Ata (WHO, 1991). As a holistic concept, community participation was meant to instil the sense that citizens and their leaders, by working together, could create a healthier society for all.

2.5 Benefits of community participation

There are two primary reasons for embracing community participation (Annett & Nickson, 1991; WHO, 1991; Dujardin, 1994). The first reason is democratic: Health participation is regarded as a basic human right. The concept is also morally consistent with the principles of fairness and self - confidence that have guided the philosophy of international development in the last decade (Whitehead, 1992). The second reason is strategic: participation is considered essential by providing additional resources to achieve social objectives. In order to extend coverage and benefits beyond urban institutions, community health involvement may be considered necessary. More pragmatically and countless field experiences may suggest that projects involving local people are more efficient and effective than projects where they are not. Schaffer (1991) has identified several benefits of community participation in health. Perhaps

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the most important advantage is the increased sense of responsibility and awareness of health and the concomitant gain in new skills and control of health resources. A related benefit is the potential for greater diffusion of health knowledge in the community and a greater use of indigenous expertise (Stone, 1986; Woelk, 1992). It is also reported that the organisation and provision of health services greatly benefits from community participation. Nichter (1984) states that health needs are more accurately determined and that resources are most likely to be allocated when the community has control over the planning and implementation of health services. With such clear advantages, one can see how the field of disability was enticed to the concept of community participation as well.

In order to achieve the health goal for all, active community participation is also a critical support activity for the PHC system. The concept of community participation has three basic characteristics. Participation must be active, people have the right and responsibility to exercise power over decisions affecting their lives, and mechanisms must be in place to enable the community to implement decisions (Victora et al., 2011). This is not just a theoretical idea, but a key principle and, if implemented in an organised way, contributes significantly to the achievement of a community or population's optimal health. Community involvement promotes participatory approaches in the planning and subsequent implementation of health care, leading to better health outcomes. Mozambique and Cuba, for example, expanded their PHC coverage in the 1980s and significantly improved their health indicators (Barreto et al., 2011). These achievements were driven largely by active involvement of the community, political will to meet citizens ' basic health needs and increased economic and social equity. While the implementation of PHC in Mozambique was fleeting due to political instability that hampered its progress, Cuba has continued to make steady progress as a result of its commitment to the comprehensive approach to PHC (Besley & Ghatak, 2007) . The population indicators in Cuba are similar to those in developed countries with relatively larger budgets. For example, life expectancy is 77 years and infant mortality is 7.7 per 1,000 live births, making Cuba one of the 25 countries with the lowest infant mortality rates in the world (World Data Bank, 2018).

The unique characteristic of Cuba's PHC system is that in Cuba, PHC is law (policy) and the basis on which the health system is based. It is not just one of many integrated approaches to the provision of health services, as is the case in other countries, but it

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is the vehicle by which all health systems are operated (Schmidt et al., 2011). The Cuban PHC system is also driven by community initiatives in which communities diagnose and identify their health priorities. They develop strategies and action plans together with government representatives to address the priorities of community health diagnosis (Shivambu, 2018).

Efficiency and equity are also an integral part of the provision of primary health care. Countries with a well - functioning PHC system (such as Cuba, Thailand, Brazil and Oman) have been shown to have better health outcomes at low cost (Victora et al., 2011). Developing countries recognise that it is desirable to take better cost - effective measures to achieve better health outcomes. For example, Ghana, South Africa, Uganda and Zambia have abolished user fees in the public sector at the level of primary care, promoting equity and increasing access to basic health services for the poor. As a result of the increase in the number of people in the named countries who have access to basic health services (especially women), infant and child mortality has been reduced by immunisation (although not to desirable levels) (Shivambu, 2018). In addition, women received basic health education through health facilities, which saw improved clean water and sanitation efforts - as evidenced by the decreasing number of reported cases of water - borne diseases - breastfeeding, involvement of households in the treatment of diarrhoea, and monitoring the growth and nutrition of children. It is therefore clear that political commitment, participation by the community, as well as cost - effectiveness and equity in the delivery of health services are key factors in the success of PHC, without which the objective of health for all remains unattainable (Keck & Reed, 2012).

2.6 Challenges to community participation

PHC emphasised participation in the community because its objective is to make development more focused on people's own ideas and actions and to a greater extent based on them. Despite its significant acceptance and continued expansion in southern countries, several researchers, academics and scholars have identified several challenges for its successful integration (Mason, Strug, & Beder, 2010). The first and most general criticism is that the ideal of community participation has not been achieved. Despite its rhetoric projects have not allowed people to think for themselves; they depend for answers and guidance on external sources (Masuka & Ray, 2017). In

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other words, participation is seen as something to be contributed by members of the community rather than an equal partnership in which villagers contribute to the planning and implementation of programmes. If real partnership is not achieved, the community will interpret its role as freedom to express opinions, but without the opportunity to implement ideas.

The second reason why the impact of community participation in PHC was not maximized is that the concept did not adequately permeate the training of local health workers and project planners were reluctant to rely on traditional resources and knowledge identified through the participation process in the community. Numerous authors within the context of PHC have argued that without indigenous expertise projects will not be sustainable (Stone, 1992; Woelk, 1992). Unfortunately, as Stone (1986) has stated, PHC has adopted a negative view of indigenous health traditions as largely 'superstition' and characterised local people as 'ignorant'. She suggests that PHC initiators stop viewing indigenous health concepts as scientifically ' right ' or ' wrong ' and examine ways to link modern health messages in ways that would increase the relevance of these messages to people (Masuka & Ray, 2017)

The third challenge to community participation is the conflict between the objective of material achievement and self-confidence building (Schmidt et al., 2011). This is often referred to as the "felt-needs dilemma." This conflict refers to the fact that the community is in the hands of the decision-making authority to determine health action. Some communities will not identify any health problems whereas external project initiators and funders may. Alternatively, even if problems are identified, communities can choose curative services, even if cure is not development, and 'experts ' may have wished to have different choices from those communities. This is not an uncommon situation. Stone: Stone (1986) writes:

…rural people are decidedly oriented toward curative services. This is not only because curative services are more impressive or more immediately gratifying, but also because these people perceive that their own indigenous knowledge already provides them with adequate preventive care, whereas effective curative services are lacking..

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2.7 Factors that have contributed to the successful implementation of comprehensive PHC

As a result of good government policies and legislation, the most successful comprehensive PHC programs are the fair implementation of efficient and cost - effective healthcare interventions. Emphasis is on the need for community and individual participation (Phute, 2016). Before any PHC program or strategy is implemented, the governing government must make a political commitment (Rohrer & Rajan, 2016). For example, Brazil's health care system is based on decentralised universal access, with local governments providing comprehensive and free health care to each person in need, financed by states and Federal Government (Barreto et al., 2011). All three levels of government in Brazil aim to encourage the disadvantaged to use the primary health care system and to benefit from it through the Family Health Programme, Brazil's main strategy for primary health care. PHC is the people's main pillar for accessing the public health system in Brazil and about 70 percent of them receive health care from this system (Phute, 2016).

2.8 Empowerment

Empowerment is one of the key components of PHC. Its various dimensions will be discussed in this section.

2.8.1 People and communities as advocates

People should contribute to the formulation, planning and implementation of policies that promote and protect health and respond to their needs and preferences in order to achieve health and well - being for all (Shilts, 1997 & Epstein, 2008). Recent health records, especially with regard to HIV/AIDS, have shown that advocacy plays a critical role, for example in increasing funding, approving new medicines, reducing the price of medicines, combating discrimination, overturning punitive laws, persuading governments to adopt evidence-based approaches and mobilising leadership (Rohrer & Rajan, 2016). At national, regional and local levels, effective advocacy can be carried out. It requires the meaningful involvement of people in the economic and political arenas, as well as specific forums and processes to record and translate into policy the stated needs and preferences of people. Mechanisms of governance and accountability that allow all people, especially those most affected by adverse health determinants, to make meaningful and broad input are essential at all levels.

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Decentralisation can help to develop policies that respond to a community's specific needs and characteristics and increase equity across regions (Bossert, Larranaga, Giedion, Arbelaez, Bowser, 2003). However, mechanisms should be in place to ensure consistency with the national vision, in order to combine the benefits of a coherent national policy with a response to the needs of the community (Eboreime, Abimbola, Obi, 2017).

2.8.2 People and communities as co-developers of health and social services

In addition to the policy level, empowered people should actively participate in the organisation, regulation and provision of health services in their communities, regardless of whether these actions are carried out by the public or private sector (Rohrer & Rajan, 2016). This enables services to respond to people's social and cultural circumstances, thereby increasing access, efficiency and responsiveness. Engagement and mobilisation in the community increase patient satisfaction improve results (as demonstrated among new-born, children and mothers) and enhance cost effectiveness (Cyril, Smith & Possamai-Inesedy, 2015). The benefits of involving people and communities are particularly pronounced with marginalised and vulnerable groups, including women and children, whose needs may not be adequately met by service delivery approaches that do not encourage engagement and co-production (Rosato, Laverack & Grabman, 2008) The participation of disadvantaged groups in the planning and delivery of services can improve responsiveness and improve the use of marginalised persons (Torri, 2012). Indigenous communities in Australia, Canada and Chile have successfully planned and delivered a range of culturally acceptable, quality and integrated social and health services as well as finding ways to deal with their disproportionate disease burden and complex political, cultural and economic determinants (Kelley,Prince & Nadin, 2018).

2.8.3 People as caregivers

Individuals, as people who experience the impact of their health and as decision-makers - play a central role in the co-creation of their own health and well-being and informal care for their peers and loved ones (Rohrer & Rajan, 2016). As a result of technological changes, in particular the rapid expansion of new health technologies and information and communication technologies, the possibilities for this have been

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revolutionised in the last 40 years. At the time of the 1978 International Conference on Primary Health Care in Alma-Ata, access to health information was often very limited (Kelley, Prince & Nadin, 2018.) Today, by contrast, the first thing many people around the world do when faced with a health problem is to use their mobile phone to search for more information, from the Internet or from other information sources that were not necessarily accessible before (Cyril, Smith & Possamai-Inesedy, 2015). Even new technologies, such as care diagnostics that can be used by health workers and patients, artificial intelligence and low-cost genetic testing, are also beginning to create new opportunities for self-care, the potential of which is only beginning to emerge. Measures will be required to ensure fair access, reliable information and support for the interpretation of complex information (Cyril, Smith & Possamai-Inesedy, 2015).

2.9 Primary Health Care in Cuba and Brazil

2.9.1 Introduction

Cuba and Brazil are used in this research because they show how stakeholder participation played a role in these countries ' access to good health services. Despite years of economic hardship caused by the U.S. trade embargo and the collapse of the Soviet Union, Cuba has maintained remarkably good health indicators that are comparable and even better than some of the world's richest nations (Kath, 2010). Much of Cuba's healthcare success can be attributed to the reforms of the Cuban revolutionary government that began in 1959, now providing free universal healthcare coverage for everyone. (Mason, Beder & Strug, 2010). Cuba currently has a comprehensive community - based health system with the largest number of doctors per capita in the world (NASW, 2011) On the other hand, Brazil's primary health care expansion experience offers three lessons in relation to factors affecting primary health care diffusion. First, the funding mechanism is critical to the implementation of the program and must be accompanied by ways to support the provision of primary care physicians in areas of low density. Second, the main challenge in more developed and larger areas is the lack of incentives to pursue universal coverage, particularly as private insurance is available. Third, population size is a key element in ensuring long - term sustainability

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2.9.2 Primary Health Care in Cuba

The Integral Polyclinic was created during the early years of the revolutionary period in Cuba (Kath, 2010). It was defined as the basic unit of the national health system, including all health activities in the geographical area assigned. At the same time, the link was established between the polyclinic and other levels of care in the national health system and gave impetus to the participation of mass organisations in the community (Schmidt et al., 2011). In 1964, the Integral Polyclinic became the centre of primary health care activities. Before that, in some cases, polyclinics were organised using the old health facilities. The "integral" label was not first used (Victora et al., 2011). The term "polyclinic" was taken from service units in socialist European countries, but it did not have the same function. In the mid-1970s, before the Alma - Ata Declaration in 1978, polyclinics were established and the family doctors and nurses program was incorporated. This allowed the health system's capacity to prevent and analyse community health and clinical services to be strengthened (Ventres & Hale, 1993).

In 1982, a general physician was required to provide services at various locations: a sugar mill, a boat, a school, an internationalist mission or an urban residential area. In the 1990s, the program placed family doctors and nurses throughout the country and served well over 95% of the population. Further changes in Cuba's primary care were introduced in 2008 (Offredy, 2008). Since 2002, there have been extensive renovations of 241 polyclinics, a process that continues today. The aim is to add services that are previously only available in hospitals. The average polyclinic currently provides 22 services, including rehabilitation, radiology, ultrasound, optometry, endoscopy and thrombolysis (Christiansen, 2010).

2.9.3 Highlights of the Cuban Community Healthcare Services

According to WHO (2008), the Cuban Community Health Services have three highlights. First, the Cuban healthcare system manages costs very well with community diagnosis and primary treatment. Second, the Cuban healthcare system's success is partly due to its unique socio-economic background. Third, active participation by the community helps to control costs and improve health promotion effectiveness.

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2.9.3.1 Cost Control by Primary Diagnosis and Treatments

The health care system in Cuba is running at a surprisingly low cost (Christiansen, 2010). This is mainly due to their emphasis on community diagnosis and primary treatment, which means that they put more effort into prevention than cures after the disease. Preventive health care is more cost-effective than curative measures, according to the health economy. Cuba has three levels of community health services. Lower-level institutions (polyclinics and family physicians) usually use more basic medicine and equipment due to domestic economic difficulties and the U.S. embargo (Rohrer & Rajan, 2016).

Although these institutions provide only the most basic health services, they provide most of the health services. Primary care is provided in Cuba in clinics, in specialty clinics, and hospitals and medical institutes (Rohrer & Rajan, 2016). The government distinguishes very clearly between preventive health care and curative measures in the Cuban healthcare system. Preventive health care focuses on eliminating risk factors that can change, such as lifestyle factors such as diet, exercise and smoking, through community interventions and early-stage individual counselling (Dresang et al, 2005). Curative measures address risk factors that are harder to change or have already become severe. Preventive health care results in desirable health outcomes by changing the behaviour of people (Whiteford & Branch, 2008). Preventive health care is therefore more cost-effective for labour-intensive countries such as Cuba than curative health care. Comprehensive general medicine which aims to prevent and treat diseases as quickly as possible is commonly used in Cuba for primary health care (Fitz, 2012).

2.9.3.2. Active community participation strategies

Another reason why preventive health care is more cost-effective is that the community usually carries out preventive activities (Fitz, 2012). This helps reduce healthcare workers' demand. It involves and serves everyone in the community. Some scholars define this as "active community participation." The concept of community participation has three basic characteristics. "Participation must be active." Dennil et al. (1998) argued that people have the right and responsibility to exercise power over decisions affecting their lives, and mechanisms must be in place to enable the implementation of Community decisions. According to Tsiko (2017) there is lack of

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community participation and most decisions regarding their health care are done on their behalf by local authority and if the community is involved, it is merely just for the sake of maintaining peace and order within the community. In Cuba, primary health care, is not just another of the many integrated approaches to the delivery of health services, but the primary vehicle, is driven by community initiatives according to Magnussen et al. (2004). The communities diagnose their health problems and identify their health priorities. They develop strategies and action plans together with government representatives to address priorities for the diagnosis of community health.

Active participation in the community also contributes to medical control through the health promotion process. According to the World Health Organization's definition, health promotion allows people to increase control of their health and improve it. It moves to a wide range of social and environmental interventions beyond focusing on individual behaviour. Greene (2003) points out those health promotion strategies are very important for the achievements of the Cuban health care system. The Directorates of Health Promotion identify as part of health promotion strategies the use of mass media campaigns and training of journalists, the general community and even special groups (Rohrer & Rajan, 2016). There is also a strategy to sensitize political leaders to change behaviour, especially Fidel Castro. The use of existing organisations and analysis of the health system in family doctors' units are also part of health promotion strategies. Public participation in Cuban health promotion strategies is high and people play an important role in determining policies and programs in public health (Donaldson & Donaldson 1994, as cited in Greene, 2003).

2.9.3.3 Socio-economic contributors

The health care system in Cuba pays a great deal of attention to eliminating health inequality. Disparity in health conditions and health resource inequality are important for the success of a health care system. The argument supporting this opinion is given by Szreter (1997). He argues that improvements in health have resulted from increased equity in the provision of basic public health services for everyone. He also points out that between reducing disparity and increasing social capital and civil will, a virtuous cycle can be created (Whiteford & Branch, 2008)

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The importance of socio-economic factors is also emphasised by Dresang et al. (2005). They argue that three types of determinants affect health outcomes:

- Non - medical determinants such as education, housing, clean air, clean water, nutrition and employment ;
- social mediators such as social cohesion, income disparities, and
- Other social structure inequalities; and health service determinants such as accessibility, universality, comprehensiveness, quality, integration horizontally, primary care focus, integration across sectors (social, environmental focus, etc) and health promotion focus.

A relative lack of large disparities in income is a social mediator which can play an important role in Cuba's health outcomes. Health outcomes are highly correlated with the country's socio-economic background (Szreter, 1997; Dresang et al., 2005). More equal access to health services will enhance socio-economic improvements and contribute to health improvements. In Zimbabwe, medical assistance is only offered to those who can afford it at any hospital or clinic and medication is also given to those who can afford it (Tsiko, 2017). Unemployment is an important determinant in Zimbabwe regarding the access to Primary Health Care. In Cuba, people are very satisfied with the government's free health services. It is important not only to build trust and commitment among the Cuban people to the government, but also to maintain a stable social order in Cuban society under economic difficulties.

- The Cuban government's high commitment can partly explain why other countries find it difficult to copy the success of the Cuban healthcare system, even if they copy the Cuban healthcare model. In 2011, free health care accounted for 10 percent of Cuba's total GDP, according to World Health Organization indicators (World Health Organization, 2011). In addition, more than 95 percent of individual health spending was paid by the Cuban government (World Bank, 2011). The accessibility of family doctors and the universality of health insurance are also important contributors to the success of the Cuban health system (Dresang et al, 2005). All thanks to the Cuban government's political will and revolutionary commitment. Baum et al. (2004) also commented on the Cuban government's high commitment to the health system. The achievements of the Cuban healthcare system are the result of the

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Cuban government's high political commitment to meet the basic health needs of all citizens, active popular participation in the achievement of this objective and increased social and economic equity (Baum et al. 1995, as cited in Magnussen et al., 2004). Reed et al., (2000) argues that improvements in health in Cuba have been attributed to the institutional establishment of the primary health care system (Reed et al., 2000, as mentioned in Magnussen et al., 2004). Health care is a citizen's right and a government's responsibility under the Cuban constitution. In addition, Cuba's Public Health Law outlines the principles of the national health system as follows:

- Socialised medicine organised by the government;
- Basic services accessible to the entire population and free to all; preventive medicine as a hallmark of the system;
- Public participation in health care; and a comprehensive approach to the planned development of the health system.

A 1997 report by the American Association for World Health, analysing the effects of the United States embargo on health in Cuba, concludes that a humanitarian disaster was prevented because the country maintained a high level of budgetary support for a health care system designed to provide primary and preventive health care to all its citizens (American Association for World Health 1997 as cited in Magnussen et al., 2004).

2.9.4 Cuba as a Model for Resource-Scarce Countries

A number of countries around the world, especially in Latin America, are now simulating the Cuban healthcare model. It is true that the Cuban health model has a great deal to learn from countries that lack resources (Rohrer & Rajan, 2016). Among the three highlights mentioned above, high cost efficiency and active participation by the community in the Cuban health care system are worth learning and other countries can also learn. They are particularly feasible in countries with limited resources, as lower costs reduce public concern about financial expenditure and increase political will to invest in health services (Kautzky et al. 2009, as mentioned in Wagawa, 2012). However, the Cuban health care system's socio-economic uniqueness also forces countries that simulate Cuba to change the model on the basis of their own situations (Rohrer & Rajan, 2016). In addition, there are some lessons that need more attention

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in addition to Cuba's valuable experiences. The two potential threats to the success of a health care system are the falling GDP and inadequate political will.

The practice of Community-oriented primary care (COPC) in the Cuban health care system could be a measure worth learning from countries with a shortage of resources to promote more active participation by the community. It is a systematic approach to health care based on epidemiological principles, primary care, preventive medicine and health promotion, which has been shown to have a positive impact on communities in the United States and worldwide (Longlett et al., 2001 as cited in Dresang et al., 2005). In Cuba, a growing number of family doctors are trained to work as part of a health care team through COPC and are also trained to provide health education and preventive services, provide comprehensive medical care and conduct population-based research. Family doctors are responsible for the members of the community they serve. Each family doctor team cares for 600 to 800 people according to the COPC principle (Ventres et al., 1993 as cited in Dresang et al., 2005).In the case of Zimbabwe, there is a shortage of doctors employed by the government and those that are employed are not satisfied by their working conditions and salaries so they resort to protesting (ZIMFACT, 2018). Dangamvura Township has one doctor who works at specific times and this is not enough service to accommodate the large number of patients seeking medical assistance.

The use of complementary and alternative medicine (CAM) can serve as a model to control costs, given the serious concerns about medical costs shared by resource-scarce countries. Complementary medicine is a non-allopathic medicine used in conjunction with conventional allopathic medicine (Barrette et al., 2003). Instead of conventional medicine, alternative medicine is non-allopathic medicine. Integrative medicine, which integrates alternative, complementary and conventional medicines, allows concepts, values and practices to be thoughtfully incorporated. These practices in Cuba are also referred to as "natural and traditional medicine," (Dresang et al., 2005). The use of natural and traditional medicine in Cuba is further explained by Dresang et al., (2005). All family doctors, who are the key to CAM implementation in Cuba, learn how to use CAM in medical schools, where CAM teaching is usually integrated into physiology, anatomy and clinical courses. Although Cuban family doctors' extensive use of CAM is partly due to the current embargo and lack of allopathic medicines, CAM is an effective way to address the shortage of medical

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resources in other developing and poor countries, where capital resources are scarce while labor resources are relatively plentiful (Kautzky et al., 2009, as mentioned in Wagawa, 2012).

The main obstacles in resource in poor countries are the reduction of GDP with shrinking health budgets and inadequate political will in view of the resistance to the implementation of the health care system (Shivambu, 2018). For example, there are two main obstacles to the implementation of primary health care in most African countries. Zambia, which began its implementation of primary healthcare in 1981, has made significant progress in the training of healthcare personnel, the rural healthcare system, the distribution of medicine, transport, and comprehensive health planning and management. Since Zambia's public finances are largely supported by its copper industry, as global copper demand has fallen in recent years, Zambia's GDP has also fallen (Feinsilver, 2010). So did their public finances. In the years that followed, Zambia experienced a shortage of health workers and deterioration in health services and infrastructure, increased the disparity in health and inequality in health resources, and even ineffective basic health promotion and prevention activities (World Health Organization 1994, as mentioned in Wagawa, 2012). Since most African countries have a single-pillar economic structure, these countries are likely to suffer from global economic fluctuations, which often lead to a shrinking domestic economy. The primary health care system in these countries cannot be effectively implemented without support from public finances. Inadequate political will is another obstacle to the implementation of primary health care (Schmidt et al., 2011.

South Africa, for example, which has relatively advanced domestic productivity and leading health concepts, still fails to effectively implement primary health care. It is partly because the governments' slow response to providing fair and health services to all people despite their background. The situation has been aggravated by intimidating state interventions, decentralised health services, poor infrastructure and services (Kautzky et al., 2009, as mentioned in Wagawa, 2012). In the meantime, Cuba is going to another level. The Cuban healthcare system achieves impressive results with limited resources with the firm determinations of its political leaders. The fact that health care is regarded as the basic right of its people makes it difficult to conclude whether the Cuban health model is suitable for another country because of the unique history and socio-economic background of the Cuban revolution (Schmidt

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et al., 2011). However, other countries can definitely learn from the high attention to preventive health care and the active community participation of the Cuban health model Feinsilver, 2010. Moreover, we expect the revolution's spiritual heritage to show the Cuban government's strong commitment to conclude whether the Cuban health model is suitable for another country because of the unique history of the Cuban revolution and socio-economic background. Other countries can certainly learn from the great attention paid to preventive health care and the active participation of the Cuban health model in the community (Shivambu, 2018).

2.9.5 Primary Health Care in Brazil

The Brazilian health system consists of a number of public and private organisations established in various historical periods (Cortez, 2019). In the early 1900s, public health campaigns were used to carry out public health activities in an almost military manner (Fausto, 2017). The authoritarian nature of these campaigns led to opposition from parts of the population and some politicians and military leaders. This opposition led to the vaccine revolt in 1904, a period of unrest in response to a mandatory vaccination campaign against smallpox, which was sanctioned by Oswaldo Cruz, the then Director-General of Public Health. The Brazilian state's model of intervention in social policies dates back to the 1920s and 1930s, when the social and civil rights of individuals were related to their position in the labour market. Brazil's social protection system expanded during President Vargas' government (1930 - 45) and the military government (1964 - 84) (Massuda, 2018).

Decision-making and management processes were carried out in large bureaucracies without public involvement. The system of social protection was fragmented and unequal. The health system consisted of an underfunded health ministry and the social security system, which provided medical care through pension institutes based on the occupational categories (i.e., bankers, railroad workers, etc.) each with different services and levels of coverage. Individuals with casual employment had insufficient public services, philanthropic care and private health services. Following the military takeover in 1964, government reforms made it possible to expand the predominantly private health care system, mainly in major urban centres. There followed a rapid expansion of coverage, including the extension of social security to rural workers.

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Between 1970 and 1974, funds were made available from the federal budget to reform and build private hospitals. Healthcare responsibility has been extended to trade unions and philanthropic institutions have taken care of rural workers (Paim et al., 2011) .Between 1970 and 1974, funds were made available from the federal budget to reform and build private hospitals. Healthcare responsibility has been extended to trade unions and philanthropic institutions have taken care of rural workers. Increased coverage of social security and a healthcare market based on fee-for-service payments from private sector providers led to a financial crisis in the social security system, which fuelled reform aspirations following the economic recession in the 1980s (Fausto,2017).

2.9.5.1 Brazilian Health Care System: an overview

There are two models of financing and delivery of health care in Brazil, namely: Sistema Único de Saúde (SUS), a publicly financed system, and Sistema Suplementar de Saúde (SSS), a privately financed system (Binge, 2010). The SUS is financed by municipal, state and federal government revenue from taxes and social contributions. The SSS is financed by individuals and employers. The SSS has been regulated by the Agência Nacional de Saúde Suplementar (ANS) since January 2000, which operates under the Ministry of Health's management. Prior to the ANS, private health insurance programs were operated on the basis of free markets and private contracts between providers and consumers (Paim et al., 2011). The SSS, which is accessible to 25 percent of Brazilians who can pay for coverage of hospital care, outpatient clinics, dental services and diagnostic tests, operates in a variety of administrative frameworks (Paim et al., 2011). Following the military government's decline, Brazilian civil society, organised in various groups of activists, promoted the reform of democratic health care, which outlined the current framework for the SUS (Andrade, 2018). This culminated in the 1986 National Health Conference of the 8th Conferência Nacional de Saúde (CNS). Bill 8,080 of 1990 (Lei Orgânica da Saúde) was incorporated into the Brazilian constitution of 1988 and provided the legal framework (box 1) for the implementation of the SUS (Paim et al., 2011). Based on the core principles of integrity (a complete package of health services), universality (for all citizens) and equity (equitable) which are enshrined in Bill 8,080 of 1990. Brazilian citizens secured the constitutional right to comprehensive and universal health care financed by the State.

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The SUS is one of the largest publicly funded healthcare organisations in the world and provides universal coverage to 190 million Brazilian citizens. Public participation in the development of SUS health policy is a constitutional right in Brazil. Federal law 8.142 of 1990 stipulates that health policymaking for the allocation of health resources will take place at the municipality's national health conferences, state and federal levels (Fausto, 2017). National health conferences are the key democratic forum for prioritising the allocation of health resources and take place every four years before each new SUS budget cycle. The participants of the National Health Conferences (CNS) are elected members of the public (50 %), representatives of health professionals (25 %) and representatives of managers and public health service providers (25%). Decision-making in the CNS takes place with the vote at the national health conferences' municipal, state and federal levels (Andrade, 2018). This process is further described in the chapter on results. Although structured public participation is a legislative requirement for the prioritisation of the SUS, decisions are taken by the leadership of private insurance companies in the setting of limitations in the privately financed system in accordance with the Agência Nacional de Saúde (ANS) guidelines and legislation (Andrade, 2018) .

2.9.6 Health Care in Brazil

The family health program (PSF) has been the backbone of the SUS since 1998 to provide universal coverage of "basic health care (Massuda - 2018)." Health care teams have a doctor, a registered nurse, an assistant nurse and four to six health workers in the community. Each team covers specific geographical areas and populations at the municipal level of 600 - 1000 families. In 2010, 85% of Brazilian municipalities had PSF teams to coordinate specialized care (Paim et al., 2011). In addition to the implementation of the SUS, significant improvements in the social determinants of health have occurred in Brazil The Brazilian health reform has made universal immunisation and pre-natal coverage possible, as well as the provision of various health services to millions of Brazilian citizens (Paim et al., 2011). In a recent series of articles, the Lancet Brazil Working Group reported on the historical development of the current health system in Brazil, which provides a comprehensive health policy analysis of government data on infectious diseases of maternal and child health, chronic non-communicable diseases, violence and injury (Reichenheim et al., 2011). During the last three decades, maternal and child health has improved dramatically

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largely because of improved social determinants of health, such as reduced poverty and improved women's education. The Millennium Development Goals to improve nutrition and decrease the mortality rate of children under the age of 5 are achieved or are set for 2015.

Challenges to improve maternal and child health, such as world record rates of caesarean sections, regional inequalities in access to health care, illegal and unsafe abortions and preventable maternal deaths persist (Victora et al., 2011). Effective health policies and interventions on social determinants of health, such as universal access to immunisation, improved sanitation and drinking water quality, have well controlled preventable infectious diseases. Infectious diseases with complex patterns of transmission, changing epidemiological profiles or for which treatment, such as dengue fever, is not effective, remain difficult to control. The causes of infectious diseases in Brazil are similar to higher-income countries (Barreto et al., 2011). Chronic non-communicable diseases, such as hypertension and diabetes, have become Brazil's main causes of death, disability and the burden of disease. Tobacco control and improved access to primary care have contributed to the decline in mortality rates from cardiovascular and chronic respiratory diseases, but obesity is an epidemic and leads to a growing burden of diabetes and high blood pressure (Schmidt et al., 2011). Injuries and violence in road traffic in Brazil are a major public health problem. In Brazil, hospital admissions due to injuries consume significant resources for health care. The total annual cost of road injuries in Brazil in 2006 was estimated at R$22 billion (CAD $10.7 billion). The main barriers to injury prevention are poor transport infrastructure and the lack of enforcement of traffic law (Reichenheim et al., 2011). Victora et al., (2011) concluded the series in Brazil with a call for action by various actors to address the challenge of improving health care in Brazil, which, according to the authors, is a political issue rather than a technical one. Their call included measures for the Brazilian government, in which the authors recommended prioritising "diseases and conditions that are increasing in frequency, including obesity, diabetes, dengue fever and others," suggesting an epidemiological approach to setting priorities (Victora et al., 2011).

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2.9.7 Universal Health Coverage

Half of the population in Brazil had no health coverage in 1988. Two decades after the establishment of the Unified Health System (Sistema Único de Saúde), more than 75 percent of the estimated 190 million people in the country rely exclusively on it for their health care (Victora et al., 2011). The family health program, which covers approximately 97 million Brazilians, is an important part of the national unified health system. It employs more than 30 000 teams of health workers who make concerted efforts to reach the poor and isolated communities of the country (Fausto, 2017). In addition to providing free primary health care at the point of service, the Unified Health System provides a wide range of hospital services, including heart surgery, sophisticated medical imaging and laboratory diagnosis. It also supports a robust vaccination program, prevention campaigns, basic dental care and subsidising many essential medicines by 90 percent. In Brazil's health-financing reform, decentralisation played a key role (Fausto, 2017).

Communities are actively involved in municipal budget decision-making. States must allocate at least 12% of the total health budget, while municipal governments must spend 15% of their health budget. The federal government is also contributing tax money (Guibu, 2017). According to Antônio Carlos Nardi, Health Secretary and President of the National Council of Municipalities Secretaries for Health, 98 percent of the municipalities meet the 15 percent budgetary requirement and some spend more than 30 percent. The municipality of Maringá, 400 kilometers west of Sao Paulo in the state of Paraná, has committed more than 20% of the total budget to health in the past six years, well above the 15% required and striking example for community participation (Andrade, 2018)

2.9.8 PHC Training

Professional training in primary health care is taken very seriously by the health department of the city. One of the clinics in Brazil is a large training centre with 18 registrars of family medicine, 8 PHC nursing students and medical students from various stages of training. Brazil is serious about training doctors and in particular family doctors for PHC, which has been reflected in its massive improvements in the country's health outcomes over the last 20 years (Guibu, 2017). More than 200 medical schools serve the population of approximately 200 million people, with another

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60 in the pipeline, half of which will be located in the countryside. Despite an increase in the number of training sites each year (a total of approximately 3,000 per year), students are not attracted to family medicine with an occupation rate of approximately 30 percent. For this reason, family medicine trainees are paid more than trainees in traditional specialist training programs, an initiative run by different district authorities, such as Rio de Janeiro (Andrade, 2018).

Table 2.1 Brazil Medical Resources

	Number of Medical schools (Population in millions per medical school)	Outputs (new doctors/year)	Medical Practitioners /10000 population	Family Physicians/10000 population	Nurses and Midwives /10000 population
South Africa	9	1300	307	0.1	51
Brazil	242	21395	19	0.2	76
India	398	52305	7	-	17
China	980	192344	14	1.2	51

2.9.9 The present Brazilian health system

The Brazilian health system consists of a complex network of complementary and competitive service providers and buyers, forming a public-private mix financed primarily by private funds (Andrade, 2018). There are three sub-sectors in the health system: SUS (Sistema Único de Saúde) in which services are financed and provided by the state at the federal, state, and municipal levels, including military health

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services; the private (for-profit and non-profit) subsector, in which services are financed in various ways with public or private funds; and the private health insurance subsector, with different forms of health plans, varying insurance premiums, and tax subsidies (Fausto, 2017). The system's public and private components are distinct but interconnected and, depending on ease of access or ability to pay, people can use services in all three subsectors.

2.9.10 Chapter summary

The literature reflects the significance of community involvement within Primary Health Care as it creates the feeling that people and their leaders can work together and build a healthier society for everyone. There is proof that demand for health care facilities is affected by socio-demographic, economic and institutional variables, particularly in African environments. These variables include, but are not limited to, education, family size, family earnings, religion, distance, health care cost, and health care quality (service availability). Brazil and Cuba are examples of how they both succeeded in deploying a universal PHC-centered health system. From the point of view of universal coverage as a goal for health systems to guarantee the right to health. There is a need to continue to show that PHC is the best way to achieve universal access, providing comprehensive and coordinated care, organizing health systems based on health needs, since it is close to people, is part of communities and is better prepared to decode and reach agreement on health needs in a more effective manner. The next chapter outlines how the study should to be conducted.

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Chapter 3: Methodology

3.1 Introduction

The methodology of this study was guided by the research problem identified and the objectives that the study sought to achieve. The study sought to critically analyse the impact of stakeholder engagement in efforts to improve Primary Healthcare in Dangamvura Township. The objective of this chapter is to describe the methodology adopted by the study. The chapter begins by looking at the study area followed by the research design adopted by the study and the research techniques employed to collect data. This was followed by the data analysis method used and the ethical considerations adhered to during the research process.

3.2 Study area

The study was conducted in Dangamvura Township in ward 7 and 15. Dangamvura is a high density suburb. It caters for people of all walks of life from the young to the geriatrics, the unemployed, self-employed and the formally employed. The economic hardships affecting Zimbabwe, have also affected the city of Mutare, let alone the township of Dangamvura. This has resulted in the decline of health care provided. This Township was chosen as a case study because firstly, it has experienced cases of outbreaks of cholera and other water-borne diseases and the people are still vulnerable to them. As an over populated township this has strained the medical sources available and therefore affecting PHC provision. Secondly, the township is where my family used to live and some relatives still live there, so access to participants was not difficult. Below is the population distribution of the Dangamvura-Chikanga Constituency:

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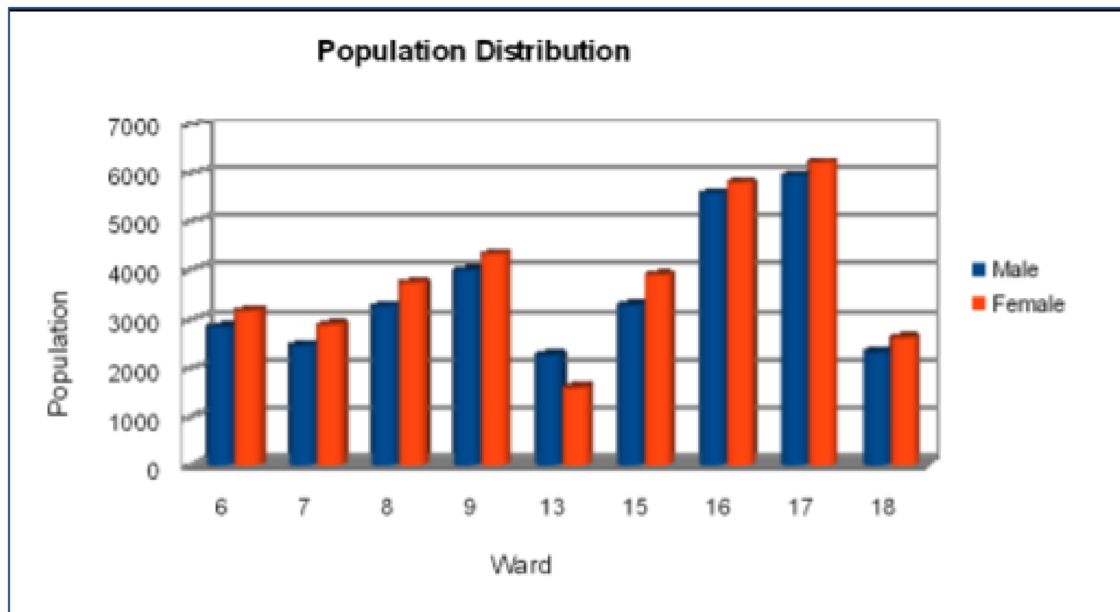
Figure 3.1: Population Distribution by Ward and Gender



3.3 Research Design

This study adopted a case study design. A case study is an object or unit of analysis about which researchers collect information to comprehend ideographic and descriptions of phenomena (Patton, 2002). The unit of study might be an individual, organisation, place, decision, event or even time period (De Vaus, 2001). I used a case study research design because it has been used by several researchers as it enables the development of comprehensive and intensive knowledge of a case to generalise a small section of a wider population.

In the study, the unit of research was Dangamvura Township, ward 7 and 15. Ward 7 is one of the first wards that was established during the war of liberation in the 1970s. The Ward has a clinic, two primary schools and a secondary school. However, Ward 15 was developed less than eight years ago. Most formal houses are not completely built and a lot of informal houses are being built. There are no proper roads, no water and electricity supply as well as institutions. In this research the researcher was cognisant of the research participants' perceptions, attitudes, and cultural beliefs towards participation.

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3.4 Data Collection

This study utilised the semi-structured interviews with a list of themes to match themes in the research objectives. The researcher also utilised questionnaires. Semi-structured interviews were used to explore ideas, beliefs, perceptions and opinions of respondents with respect to promoting stakeholder participation to improve Primary Health Care. On the other hand questionnaires were used to gather information about the opinions and behaviour of individuals on a larger scale. The use of semi structured interviews enabled the researcher to probe for detail, triangulate data collected through questionnaires and seek clarification of the content of questionnaire results. Interview questions were rephrased for clarity through a pre-testing with selected health personnel, which gave the researcher an opportunity to probe and explore themes under study further, resulting in the collection of rich and detailed data.

The researcher identified key informants (former and current councillors, the former mayor, nurses, doctors, health promoter and patients who were also community members. These participants were interviewed through the semi structured interview sessions based on level of authority either in the donor community or public health system structures (assuming higher authority came from experience) and depth of knowledge sought from the study. An invitation to participate in the interview was sent out to target respondents, and a written consent was acquired before commencement of the interview. Interviews were recorded using a cell phone and notes were also taken during the interview. Questionnaires were administered to community members, who also receive services from either Dangamvura polyclinic or Save Clinic . It was essential to pre-pilot the questionnaire to identify any ambiguities in the questions and to identify the range of possible responses for each question.

3.4.1 Desk Study

This study involved the review of previous studies and policy documents on Primary Health Care in Zimbabwe. This included strategic government documents, healthcare reports, academic articles, and WHO Reports which also includes the Alma- Ata report. The Zimbabwe Health System Assessment Reports from 2010-2016 were reviewed and gave insights on the health system, examining the different synergies, policies, and issues that affect health care delivery. The 2017 Health and Child Care Budget Brief highlighted major issues of concern to health in Zimbabwe exposing that

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budget allocation to the health sector in Zimbabwe is low compared to other Africa countries and that the basic level of health system in Zimbabwe is highly dependent on donor funding. This information was useful on giving key details on how Zimbabwe is not prioritizing primary health care as much as it is expected to. The Alma –Ata report of 1978 expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It showed how different stakeholders have to work together in order to improve primary health accessibility while maintaining a sustainable services and standard. News articles from ZIMFACT & ZIMSTATS (2018), report on the need for stakeholder participation to improve the health service delivery.

3.4.2 Key informant interviews

Key informant interviews have been widely used in the field of development. In this context, they enabled us to acquire expert knowledge on key issues such as stakeholder participation and primary health care upon which the study is grounded. Key informants (former and current councillors, the former mayor, nurses, doctors, health promoter and patients who were also community members) were chosen to provide information pertaining to healthcare service delivery in Dangamvura and whose knowledge of health promotion, health care services and community health programs, was valuable to the study. Key informants were selected based on their knowledge, availability, willingness, experience of the subject area and the number of years they have lived in the township. A total of eighteen (18) key informants were identified and interviewed. The participants included the former Mutare Mayor, who provided information pertaining government involvement in primary health, the level of community involvement, NGO assistance, the impact of politicians on health and the initiatives made by the local council to improve Primary Health Care.

The health promoter gave information about the health programs they initiate, the demand for the programs, and who they partner with during their outreach programs. Such information assisted in knowing the basic healthcare available and where more assistance was required. Nurses and doctors provided information regarding the health programs provided by the clinic, how they are involved in community outreach programs, their personal understanding of PHC and their involvement and their relationships amongst other stakeholders. The researcher intended to interview 3

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doctors but there was only one doctor who attends to patients on scheduled times at the clinic. Sisters-in-charge were responsible for the day-to-day duties at the clinic. The patients gave their view on the service they received at the clinics, their participation level in healthcare and their expectations regarding healthcare care in the community. Lastly, the current Dangamvura ward 7 and 15 councillors and former councillors provided information on the participation level of the community, how they mobilise the community to attend health programs, the health challenges they face in the community, and their view on government involvement.

Each interview was conducted face-to-face and it lasted approximately 40-60minutes. There were guiding open-ended questions which also allowed the participant to explain other views and even bring in new relevant ideas that may not have been asked. One characteristic of these interviews was that the respondents were enthusiastic and enjoyed the discussion to such an extent that they provided useful and authentic information.

3.4.3 Questionnaires

The questionnaires administered in this research were given to twenty community members who were selected using purposive sampling just as the interviews. The criteria used were age which ranged from 16-60, their occupation and distance from the clinic. The questionnaire was constructed using a combination of closed and open-ended questions. The first part of the questionnaire had close-ended questions, which provided the respondents with a selection of responses to choose from. The last part had open ended questions in order to capture the feelings and experiences of community members (patients) in Dangamvura. Open-ended questions allowed respondents to communicate their experiences or opinions about a specific issue in their own words without any restriction (Terre Blanche et al, 2006).

3.4.3.1 Pre-Piloting the questionnaire

The validity as well as the reliability of the measurement tool, that is, the questionnaire, needs to be rigorously tested to ensure that the data collected is meaningful. The design as well as the method of administration of a questionnaire will also influence the response rate that is achieved and the quality of data that is collected. Consequently, I conducted pre-pilot studies with friends and family informally in order to gather information as well as explore the questions together to identify potential

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problems. After each session, the questionnaire was amended before re-piloting with another group of respondents. Williams (2003) emphasised that this process should instil confidence in the researcher that the questions are unambiguous, appropriate and acceptable to the respondents. It also tests the layout of the questionnaire at this stage to ensure that people can navigate their way through the questionnaire

3.4.3.2 Piloting the questionnaire

Before any questionnaire is delivered, it should be "piloted" (i.e. tested) to check that it is going to function effectively. Piloting will provide a guide for rephrasing questions to invite a richer and detailed response. I suggested that it was better to collect fewer questionnaires with good quality responses than high numbers of questionnaires that are inaccurate or incomplete. Ideally, it should be piloted on a group similar to the one that will form the population of the study about twenty percent of the final sample number. On completion of the pilot questionnaire, respondents were asked to answer the following questions in writing:

1. How long did it take to complete?
2. Were the instructions clear?
3. Were any questions unclear or ambiguous?
4. Did you object to answering any questions?
5. Was the layout clear and attractive?
6. Any other comments

In addition, the written responses to the above six questions of the pilot study was also discussed and the researcher made written notes of the views of all the participants so that the questionnaire could be corrected/ amended accordingly.

3.4.3.2 Design of the questionnaires

The questionnaire that was developed was used to collect the primary data from the respondents for the study. The aim and objectives of the study were considered when designing the questionnaire. The construction and design of the questionnaire involved pre-pilot studies as well as pilot studies. These took the form of several drafts, which entailed a fair amount of time for refinement until the final research instrument

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was formulated. The questionnaire comprised structured questions (closed questions) in which respondents were given a set of alternatives from which he/she could choose to answer the question and also open ended questions. These structured questions were dichotomous questions and rating scale questions.

3.4.3.3 Description of the interview guide questions

The interview guide for the community members, medical practitioners and community leaders comprised of the following five sections:

- ***Section A***: *Demographic data*

It was necessary to analyse the demographic profile in order to discuss aspects of PHC and their participation role.

- ***Section B***: *Professional experience, for example, general, PHC experience and policy issues*.

This section aimed to eliciting the respondents' understanding of PHC (knowledge, principles, and strategies for implementation)

- ***Section C***: *Factors that may encourage or discourage PHC engagement*.

The purpose of this section was to identify factors that may encourage or discourage the respondents to engage in PHC.

Section D: *Participation*

This section aimed to discuss the different participation roles of PHC stakeholders in the community and their level of participation.

- ***Section E***: *An integrated approach to PHC delivery at a clinic level*

This section aimed to examine the integrated approach to PHC delivery, which involves teamwork, training and intensive collaboration.

3.5 Sample and sampling techniques

The study used probability random sampling in administering questionnaires for the community members / patients so as to attempt to be evenly representative of gender as well as the different services they receive at the clinics. A total of twenty

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questionnaires were administered during data collection. Purposive sampling-snowballing was the non-probability sampling method that was used to identify stakeholders to be interviewed such as healthcare practitioners, community leaders and members. This method was used for interviews because the probability sampling methods could fail to pick up even one practitioner, so it was significant to use purposive sampling which Bryman and Bell (2003) described as sampling with a purpose which include people of interest and exclude those who do not suit the purpose. A total of eighteen interviews were done during the data collection period. These sampling methods was used in Dangamvura Township which has a population of about 47 120 as mentioned in the section 1.4, the majority of whom work in farming, mining and forestry industries. According to the 2012 Census, the majority of the youth relocated to the capital city of Harare but this did not have an effect on my study. In order to show a representative sample, both the interviews and questionnaires showed a diversity of the population which varied in terms of age, gender, legal status, and years of experience to identify a heterogeneous sample as possible.

3.6 Study population

The table below provide a summary and overview of the participants of the research participants.

Table 3.1-Characteristics of Participants Interviewed

Real Name	Pseudonym	Age	Gender	Occupation/ participant role
Tatenda Nhamarare		35	Male	Former Mayor
Mwanyara Jusa		45	Female	Former Councillor (Ward 7)
	Mr Phiri	43	Male	Former Councillor (Ward 15)
	Mrs Hove	38	Female	Councillor
Naomi Muzandaka		47	Female	Nurse
Cindy Runoza		24	Female	Nurse
Mrs Kadzunge		51	Female	Sister-in-Charger
Dr Kudzai Murembwe		29	Female	Doctor (Curative Officer)
	Dr Moyo	62	Male	Doctor (Retired)

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	James	28	Male	Health Promoter
Amanda		26	Female	Patient & community member
Sandra		18	Female	Patient & community member
Nyasha		30	Male	Patient & community member
Boniface		27	Male	Patient & community member
	Praise	57	Female	Patient & community member
	Sharon	42	Female	Patient & community member
	Max	51	Male	Pateint & community member
	Tatenda	32	Male	Patient & community member

3.7 Data Analysis

Data collected through document analysis, interviews and questionnaires were analysed using a thematic analysis approach to qualitatively analyse, identify and report recurring patterns emerging from people's experiences (Braun & Clarke, 2006). Interview data was collected in written format and the data analysis entailed a word-for-word transcription of interviews. Constructs and patterns were taken note of in each individual case for case validity and also in relation to existing literature. In the process of analysing interview findings, a tabular format was utilised whereby similar themes were grouped and analysed in order to distil the common themes emerging from the data. The table included the findings, the details of the response as well as representative quotes that encompassed a direct link to research questions and were comprehensive in capturing all the information from other respondents.

The main purpose was to look for broader patterns in data and this was achieved through a rigorous process of data familiarisation, coding, theme development and revision The main themes gleaned from respondents were meant to gather information on how stakeholders can be involved in improving primary health care. The main advantage of thematic analysis in this study was that it was simple, took less time and was theoretically flexible because the researcher intended to collect people's views, experiences, belief and perceptions on a particular phenomenon facilitating the researcher to organise and describe given data in richer and informative detail.

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3.8 Verification of Data

3.8.1 Reliability

The participant's error or bias can result in threats to reliability. In order to increase the reliability of the current study, the researcher used a mechanical method of testing and re - testing the questionnaire to ensure that the research tool reduced measurement errors and produced consistent results. In trying to derive consistent findings, all respondents received a similar questionnaire to complete on their own; some of the questions were standard structured questions when respondents simply ticked a response that closely matches their uniformity perceptions. Triangulating the two data collections instruments, though the combination of the interview and the questionnaire enabled the study to counter weaknesses of either data collection method.

3.8.2 Validity

This study observed the rules of research validity and is mainly guided by construct validity, of which the construct here was the initial concept, notion, question or hypothesis that determines which data is to be gathered and how it is to be gathered. Validity was mainly determined by asking a series of questions in the pre-testing phase to determine whether questions asked were valid, measuring what they were intended to measure, appropriate for the target population and whether they were comprehensive enough to collect all the information needed to address the purpose and goals of the study. In the study, the researcher improved face validity by ensuring that lead questions in the questionnaire did not influence respondents to answer in a specific way.

A single blinded technique was utilised in order to improve internal validity. This entailed that participants were deliberately interviewed separately so that the views of the dominant members could not influence the views of others. In other words, internal validity enabled the participants not to behave in a certain way that they might have thought to be expected of them. Interviews complemented findings from the questionnaire to ensure internal validity.

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3.9 Ethical Consideration

The researcher ensured that the respondents had the right to self-determination. Participants were debriefed and given adequate information regarding the research; this enabled them to develop the power of free choice enabling them to consent voluntarily to participate in the research or decline participation. As such the research sought written permission from the participants. The purpose of the study was explained to participants and the researcher read the statement introducing to the topic under study before getting their consent to participate. Participants were informed of their rights to withdraw from the study any time. Written consent was sought and granted by the University of Pretoria.

Also, the researcher ensured that participants enjoyed the right to confidentiality. The researcher read the statement of confidentiality before the start of interviews, data collected was used for academic purposes only and all information was treated in strictest confidence where interviews transcripts and questionnaires were destroyed after data collection and analysis. In guaranteeing the right to privacy, the researcher maintained privacy on participants' feelings, beliefs and attitudes that arose from this study by ensuring that raw data was protected from unauthorized persons, not shared and no names were linked to the data. To this end the researcher pledged to respect the views of the respondents. Any information derived from the respondents was held in the strictest confidence and pseudonyms were used to protect the respondents in the final write up of the study. The data was used purely for academic purposes

3.10 Chapter Summary

This chapter presented the research design and methods adopted in this study. The research design used was qualitative in nature. A case study research design was used as it has enables the development of comprehensive and intensive knowledge of a case to generalise a small section of a wider population. To collect primary data, semi-structured interviews were conducted with medical practitioners, community leaders and members. Questionnaires were administered to community members randomly as well. Secondary data was gathered from articles, journals and newspaper articles. Probability sampling was used to obtain a sample that was representative of the population and from which generalisations to the population can be made. The last sections of the chapter presented detailed information of the data analysis procedure,

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which involved a content and thematic analysis, as well as ethical considerations. The next chapter presents the outcomes of the methodology, presenting and analysing the data collected.

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Chapter 4: PHC implementation in Zimbabwe

4.1 Introduction

Good health is essential for productive and fulfilling life and is essential for promoting sustainable development. Healthier nations are richer countries. Zimbabwe has a strong framework for policy and the institutional environment to ensure healthy lives and promote well-being for everyone. Zimbabwe's Constitution recognises health as a basic human right. Section 76 of the Constitution provides for the right to health. The government has also developed a national health strategy for Zimbabwe for 2016-2020 aimed at achieving "equity and quality in health: No one is left behind." This chapter will examine how Primary health care in Zimbabwe was implemented within the national and community level.

4.2 Zimbabwe's Demographic Profile

In the 2012 national census, the total population of the country was estimated at 13,061,239, comprising 48 percent of males and 52 percent of females, with 67 percent being the rural population. The total population nearly doubled in 1982 from 7.5 million. According to the World Bank, the national population was estimated at 16.2 million in 2016, compared to 15.8 million in 2015 (Phute, 2016). (See, Table 2.1 below). The population growth rate in Zimbabwe continues to be relatively high and life expectancy is improving, albeit on a lower basis. As a result, there is a large population of young people and working people who have enormous potential. The challenge is to convert this potential into a demographic dividend by increasing their capacity and productivity (tangible development benefits). Converting this youthful population into a demographic dividend will require scaling up investments in healthcare and education among others (Phute, 2016).

The high mortality rate in the reproductive age group (15-49) due to HIV and AIDS has deteriorated the dependency ratio, leaving an estimated 25 percent of children

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orphaned and vulnerable to elderly care (ZIMFACT, 2018). There are regional differences in urban disparities, where rural women have higher fertility rates than urban women. In particular, among women, high fertility rates are linked to high poverty and inadequate economic opportunities (Chikwature & Chikwature, 2019). Demographic trends in Zimbabwe will affect government spending on health. As people live longer due to improvements in life expectancy, it is projected that the elderly population will increase and therefore require more resources to be allocated to social services, including healthcare (ZIMFACT, 2018).

Table 4.1: Zimbabwe's Demographic Profile 2016

	2000	**2005**	**2010**	**2015**	**2016**
Population Growth (annual %)	1.3	1.3	2	2.4	2.3
Population (million)	12.2	12.9	14.1	15.8	16.2
Fertility rate	4.1	4	4	3.9	-
Life expectancy	41.7	41.8	49.6	59.2	-

Source: World Development Indicators (2016)

4.2.1 Primary Health Care in Zimbabwe

Following independence, the Government of Zimbabwe (GOZ) sought to address past imbalances by providing integrated health services based on the principles of acceptability, affordability, accessibility and adequacy of health services (Nyazema, 2010). In an effort to achieve equity and better quality of services, the GOZ adopted an independent PHC policy that is more affordable, accessible and appropriate to the needs of the majority of the population. The development of post-independence rapidly improved the health sector for most people from less than 60% in 1980 to more than 80% in 1990. Shamu, S. Loewenson, R., Machemedza, R. and Mabika, A. (2010), adds that three waves of social economic developments shaped the health sector in Zimbabwe; a period of high public spending (1980 - 1990), followed by liberalisation

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and provision (1990 - 2000) and the current economic down turn (2000 to present). The later period also saw a serious decline in the health sector, human resources as professionals and qualified health staff members leave the country to better pay economies in the region and abroad.

4.2.2 Health Policy

The Ministry of Health's (MOH) policies in the 1980s were influenced by the "Growth with Equity" economic policy adopted by the Government of Zimbabwe to redress pre-independence imbalances. The MOH therefore created a policy document entitled "Equity in Health" with equity as the key value of the policy. The primary focus of the policy was to enhance the majority of people's access to health services. A translation of these overall goals into programs and services was the Zimbabwe Health for All Action Plan (1986). In rural regions, deliberate emphasis was placed on rural infrastructure growth, personnel preparation, more personnel deployment and the setting up of the required management mechanisms (MOH, 1999). Primary health care has been and continues to be the driving force of the entire health care scheme. However, changes in the socio-economic setting at home and abroad and fresh health challenges such as HIV / AIDS required a re-examination of present policies and programmes. Concerns for quality, efficiency and equity dominate in most recent policy documents. In line with these changes the MOH has produced a National Health Strategy for Zimbabwe (2016-2020): equity and quality in health: leaving no one behind. A key ingredient of this strategy is the health sector reform.

4.2.3 Post Independence (1980-1990) and the PHC

The post-independent health policy of Zimbabwe reflected the broader natural objectives set out in the National Transitional Development Plan, which stated that "the establishment of a society based on socialist, democratic and egalitarian principles and the end of imperialist exploitation by a more equitable ownership of the means of production by Zimbabwe" (Sanders, 1990). This health system was intended to be integrated into other development programs, such as rural infrastructure, education, housing and food production. The main task in 1980 was to restore and rehabilitate the war-torn infrastructure. In order to improve nutrition and control preventable diseases, the adoption of the Primary Health Care (PHC) approach required the allocation of new resources to previously deprived areas. The policy

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emphasised the conscious and active involvement of communities in the transformation of their own health. Johnston (1998) states that, since the government expressed its recognition that the causes of ill health lay in the conditions of people's lives and in the context of an urban racially and curatively biased health care system, in 1980 it guaranteed the transformation of health care so that all citizens would have access to a comprehensive integrated national health service.

Sanders (1990) points out that, in line with the new approach to PHC, the management and delivery of care has been slowly transformed and some of the changes introduced since independence have been the development of free health care, hospital and rural health care. Zimbabwe has expanded immunisation, diarrhoea, disease control, national nutrition and child spacing programmes. All these and other programs required expansion of government spending, which grew significantly after independence. Kaseke (1998) on the other hand, adds that the PHC policy emphasises preventive services, reflecting the government's changing philosophy. The colonial government's neglect of rural areas forced missionaries to take corrective measures to assume greater responsibility for the provision of health services in rural areas.

4.2.4 Liberalisation and provision (1990-2000)

The health care system in Zimbabwe is highly liberated. The state sector operates in rural areas together with private operators for profit in urban areas and church-based healthcare. The state sector, however, serves the urban and rural population with higher health needs for the lowest income (Johnston, 1998). After independence, the new majority government invested heavily in social services and resources to provide universal education and health care. GOZ focused on improving access for the marginalised black population to services and targeted rural communities. Shamu et al., (2010) adds that the "Growth Points" policy for the construction of "urban centres" in rural areas has cemented the strategy. These centres have been designed to provide a full range of services and have also been designed to be the main health centres for the rural population. The centres were provided with a general hospital, which also served as the basis for the delivery of health services to remote rural hinterlands (Shamu et al., 2010).

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Accordingly, Sanders (1990) points out that democratisation are a central feature of the PHC approach, which is essential for genuine participation by the community and which benefits both sides. Therefore, programs for community health workers (VHW), which are democratically controlled by the poor majority, can serve not only the purpose of extending health care to even isolated communities, but also of mobilizing people to transform their living conditions and thus their health.

On the other hand, Johnston (1998) points out that by the beginning of the 1990s, the prevalence rate of adult HIV in Zimbabwe had already reached 10 percent, but political leaders resisted recognising the scope of the AIDS pandemic. The GOZ therefore began to prepare for the ESAP launched in 1991 with the World Bank and the IMF. According to Johnston (1998), the GOZ and the World Bank initially believed that ESAP would lead to increased growth and would protect social sectors and the poor. Johnston believes that this was false hope. In the 1990s, the private provision of health services rapidly increased and expanded, contributing to a shortage of staff in the public health sector. At the request of the MOHCW, AIDS prevention was carried out under a new STI project, which responded to the AIDS epidemic due to a critical shortage of government funds for the procurement of drugs

4.2.5 State and Trends in Key Health Indicators (2010-2017)

The health care allocation of the government continues to account for a relatively small proportion of total government expenditure, with a health sector allocation of 6.9% in 2017. However, the cost of employment represents 79 percent of the total health budget. The Abuja target remains an elusive target for Zimbabwe (ZIMFACT, 2018). Total government expenditure on health as a percentage of total government expenditure was less than 15% (Abuja target) over the period 2010-2017 as shown in Table 3.2. The government also spends relatively little on health care in its gross domestic product (GDP). Lower levels of health expenditure per capita indicate that the country's health expenditure is insufficient to ensure adequate access and quality of health care. The health allocation per capita is down from US$24 in 2016 at US$21 (Phute, 2016). This means that in 2017, the government spends an average of US$21 per person on health care, which is grossly inadequate. When you remove the employment cost component, the per capita allocation is much lower. The health allocation per capita is lower than the US$146 SADC average. The health allocation

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per capita in South Africa is US$650, Zambia is US$90 and Angola is US$200 (ZIMFACT, 2018). The total allocation of health was also lower than the Abuja target of 15 percent and the African sub-Saharan average of 11.3 percent. Countries like Malawi, Rwanda, Madagascar, Togo and Zambia have succeeded in achieving the Abuja target, according to the WHO. Rwanda spent at least 23 percent of its health care budget as of 2015 (Phute, 2016)

Table 4.2: Trends in Health and Child Care Allocations (2010-17)

	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Health Allocation (% of Total Government Expenditure	7.7	7.9	8.6	6.6	8.2	7.3	8.3	6.9
Public Health Spending (% of GDP	1.7	2.1	2.8	2.8	2.5	2.2	2.3	2.0

Source: Various Government Budget Statements; World Development Indicators (2017)

Despite challenging economic conditions and diminishing national budget allocations for health, Zimbabwe has made significant progress on the health front, largely due to external financing from development agencies (Chikwature & Chikwature, 2019). These gains are associated with significant decreases in the prevalence of HIV, child mortality, maternal mortality, increased child vaccination and increased life expectancy. Not with standing these milestones, significant income and urban/rural differences in key health indicators need to be eliminated in terms of coverage and outcomes (Chikwature & Chikwature, 2019).

4.3 Legislation

The Zimbabwe health delivery system is built on the constitutional right to health care in Section 76, sub-section 1-4, of the Zimbabwe Constitution, which states that:

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- Every citizen and permanent resident of Zimbabwe has the right to have access to basic health care services, including reproductive health
- Every person living with a chronic illness has the right to have access to basic healthcare services for the illness
- No person may be refused emergency medical treatment in any healthcare institution *and*
- The state must be take reasonable legislative and other measures within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

Figure 4.1- National health strategy 2016-2020

4.4 The referral process within the PHC

The government of Zimbabwe operates a four tier health system as indicated below:

<u>The progression of the PHC referral system in Zimbabwe</u>

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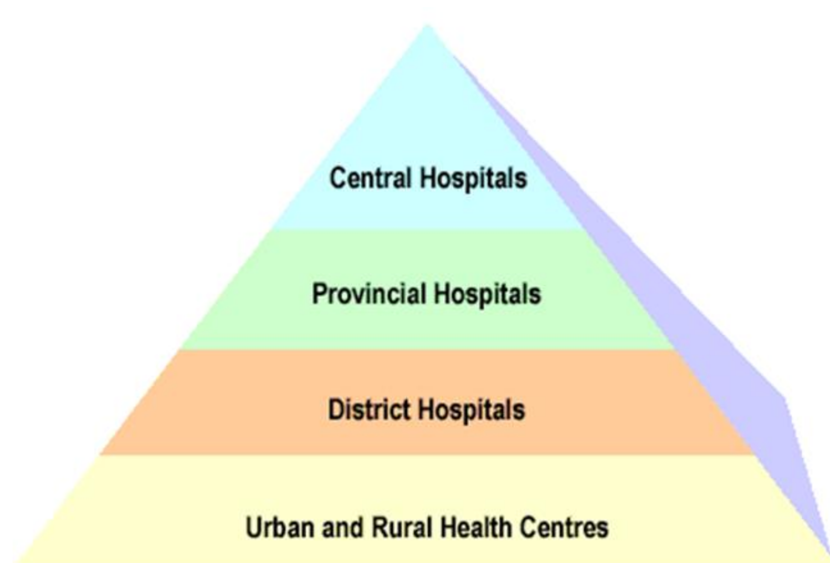
Figure 4.2 -Source: Shamu et al., (2010)



Less developed countries such as Zimbabwe instituted primary health care (PHC) systems, and developed a pyramidal referral model to support the primary care level. Clinics and district hospitals were intended to provide local services for uncomplicated cases, referring patients with more serious conditions to regional/provincial and central hospitals (Sanders & Davies 1988; Loewenson et al. 1991; Loewenson 1993). In theory, patients must first appear at the entrance level and then be referred gradually upwards if the condition justifies such a referral (Phute, 2016). However, the Health Ministry has admitted that the referral process works poorly in practice. The conditions of rural health facilities are so poor that people circumvent them and refer to higher - level facilities in order to obtain the desired care. Only central and better general hospitals offer the most basic medical and surgical care. This is why people pass their local health facilities and put pressure on services on large institutions, in particular the central hospitals (Masuka & Ray, 2017). The PHC approach should provide a chain of increasingly sophisticated facilities so that the line can be referred to patients with more complex conditions. In practice, the referral process works poorly and people pass their local health facilities and put pressure on the service of larger institutions, in particular the central hospitals. Sanders (1990) opine that, despite the government's enthusiastic PHC drive and its stated commitment to equity in health, the referral system appears still to function poorly.

4.4.1 Health Care Workers within the PHC

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Human resources are key factors in the success or failure of health systems, and the performance of health care systems depends on the availability, know-how, mix of skills and motivation of staff services. Mudyarabikwa and Mbengwa (2006) add that many of the improvements achieved in the health indicators during Zimbabwe's first ten years of independence are declining. This is due to the lack of qualified and experienced health care workers at a time when demand for services is growing due to the challenges posed by HIV and AIDS.

Mudyarabikwa and Mbengwa (2006) state that during ESAP in the 1990s, policies to increase the number of health workers were rejected or abandoned. The IMF and the World Bank did not exempt the health sector from austerity measures aimed at rationalising public service. The Public Service Commission (PSC) and not the MOHCW employs healthcare workers that create disparities in policies concerning the distribution of healthcare workers. In practice, MOHCW determines ideal personnel requirements to provide minimum health packages, but does not have the power to increase jobs beyond the establishment established and approved by the PSC. Mpofu and Nyahoda (2008) maintain that the establishment approved by the PSC is lower than the ideal requirements of MOHCW for a number of reasons and for almost all categories of health professionals. The positions approved by the PSC are even lower than the minimum WHO standards set out in the Ministry's Human Resources Master Plan. In health professional groups, the highest loss incurred in Zimbabwe has been on doctors, nurses and pharmacists although other non-clinical health workers are also affected. In line with this idea, Chikwature & Chikwature, (2019) point out that poor benefits and professional problems, such as lack of resources and facilities, heavy workloads and insufficient opportunities for promotion and self - movement, are reported to be the main causes of these losses among health workers. Mudyarabikwa and Mbengwa (2009) observed that urban public facilities are still known for congestion and delayed services for patients despite the provision of more staff, because not all jobs are filled.

4.4.2 Partnerships with the private sector

Zimbabwe's private sector plays a major role in both financing and delivery of health services, and this role need to be strengthened (Masuka & Ray, 2017). Seizing possibilities for government within the private sector requires awareness that it is not

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a homogeneous industry. On the one side, it has the private-for-profit sub-sector, which involves, for instance, autonomous suppliers such as clinics and hospitals, as well as pharmaceutical, device and machinery sectors. However, it also has the private non-profit subsector, which contains mission centres, non-governmental organisations and other charitable organisations, as well as medical assistance societies engaged in financing health care, especially for the middle class (Masuka & Ray, 2017). Missions have a lengthy history of being component of the domestic health care scheme with regard to service relationships; however, support for missions through public grants has declined in actual terms over the years.

In addition, due to the lack of formal service contracts defining what is expected in some cases and or the limited capacity of the Ministry of Health and Child Care (MOHCC) to effectively monitor and manage these grants, there has been limited monitoring of the disbursed grants to these institutions (Government of Zimbabwe, 2013). Some provinces have established these formal management mechanisms and similar actions are necessary country-wide. In some instances, mission facilities are designated as district clinics, for example, to help the referral scheme, but there are sometimes difficulties in these districts ' management and coordination tasks due to the dual mission governance structure - government and church. Traditionally, local government, like missions, finance and deliver health services in their fields. Local councils have recently experienced issues with financing specifically for health facilities (Tsiko, 2017). Their health infrastructure and facilities has worsened and the numbers of health employees have shrunk, creating more inequalities in accessing vital health services, especially in rural regions. It is essential to harmonise local government health facilities and service norms with those of the MOHCC, particularly primary health care. Suggestions were made during consultations that the MOHCC should take over local government facilities.

The private for-profit industry offers possibilities to extend access to quality services beyond the middle class, but the lack of a defined public-private partnership structure within which to work is a main challenge. Among other things, the Public Health Act and the Medical Services Act provide the legislative basis for regulating the private sector, but in relation to existing self-regulation, especially among professional organisations and autonomous suppliers, there is a need to reinforce and create suitable organisations to regulate the industry (Tsiko, 2017). With the implementation

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of new types of health funding such as domestic health insurance, wider involvement of private suppliers is likely to be improved.

Medical Aid Societies and health insurance businesses are presenting possibilities for the health industry to be supplemented by tapping into the increasing middle class. Such possibilities, however, rely on financial prospects and job development (ZIMFACT, 2018). With suitable legislation and governance arrangements, these organisations can possibly help the government in fulfilling its health goals of increasing access to quality services.

4.4.3 Active community participation

Communities need to be seen not only as health service beneficiaries, but also as those services' co-producers. Their capacity to engage in the financing and delivery of services relies on their capacity to engage in these operations. Community involvement or participation is the cornerstone of creating powerful community health systems (Masuka & Ray, 2017). The Constitution describes health care as a right to be enjoyed by all, and that right needs adequate, acceptable and accessible services to be provided to the inhabitants. It also implies the health care system needs to be responsive and responsible to their requirements. Community participation structures exist at local levels such as the Village Development Committees (VIDCOs) and the Ward Development Committee (WARDCO) and through Health Centre Committees (HCC) and Hospital Advisory Boards at facilities levels (Government of Zimbabwe, 2013). However, the challenge has been that these structures are not always functional. Together with the Village Health Workers and Environmental Technicians, there are now opportunities to use current PCNs to enhance main care community engagement operations. The participation of other community leaders and traditional governance will increase demand for services, as well as accountability for their health status for the society and individuals. In creating a feeling of community ownership and accountability, empowering communities to participate in health service planning and offering multiple forums and channels at different levels for community involvement is essential (Tsiko, 2017).

The Patient Charter needs to be revived in this regard. Community consultations have shown that communities are worried whenever they need access to quality facilities (Masuka & Ray, 2017). They raised problems such as shortages and attitudes of

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health workers, accessibility of drugs and equipment, transportation of patients, hospitalisation facilities such as beds, food and ablution centres. The approach is intended to deal with these problems. Accountability systems and structures at all levels were reported to operate sub-optimally. These structures (e.g. Health Advisory Board) need to be upgraded for them to operate efficiently and setting up a social partnership with the society provides possibilities for individuals to understand what to expect from the health care scheme and, more importantly, to know what to do in instances where there is no or poor service delivery (ZIMFACT, 2018). Coordination of multiple community-level partners is critical to ensuring that the various partners, i.e. other government agencies and non-governmental agencies function in harmony towards agreed objectives in these groups. Ensuring that health is seen as an essential aspect of other industry programs will go a long way in tackling the difficulties of cooperation (Shivambu, 2018).

4.5 Chapter summary

The chapter began with conceptualising Primary Health Care as the key concept of the study. It is seen as a way of enhancing the health status of the entire population without any general change in the social and political system. From the above debate, it is evident that over time distinct policies have been put in place in Zimbabwe in an effort to enhance the country's health system (state of people and health facilities) in particular. Despite the multiplicity of such approaches, the country's overall health status has not improved to a large extent. Zimbabwe is facing multiple economic difficulties that make it hard for the government to implement any policy for improving health efficiently as financial and other health resources are required. It can be asserted with a fair degree of certainty that the country's bad financial performance is due to the absence of achievement of some of the policies or strategies. Also impacted are PHC stakeholders like doctors and nurses, who are facilitators of demonstrating health services at health centres. They are compelled to strike for better remuneration against the government. They and the community could enhance their involvement in the PHC in Zimbabwe, especially Dangamvura. The next chapter demonstrations how Cuba and Brazil are good examples of how primary health care should be like.

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Chapter 5: Analysis of Primary Health Care findings

5.1 Introduction

This research study investigated the impact of promoting stakeholder participation to improve Primary Health Care in Dangamvura. This chapter presented the results gathered from the interviews that were conducted in Dangamvura Township with a total of 18 participants (6 health-care providers which include doctors, nurses and a health promoter, 3 former and current councillors, 8 patients and the former mayor) and questionnaires administered to twenty participants. Interview participants were recruited and selected as explained in Section 4.6. A semi-structured interview schedule was used. The participants articulated their experiences of the current activities in primary health care. A cell phone was used to capture the conversations as they happened and soon after the interviews, the information was transcribed.

5.2 Participation and influence of stakeholders in the management of Primary Health Care in the township of Dangamvura.

This section of the study analysed if stakeholders participate enough in improving PHC and whether they have a say in the management of PHC.

5.2.1 Stakeholder perceptions on participation in PHC

This section explores the perceptions of stakeholders about their roles and levels of participation. The study reveals some variations on how participatory processes were perceived by stakeholders. The participants' response further indicates how they perceive their participation. For example, the exploration focuses on who influences decision-making and determines the appropriate service delivery. Some believe that their participation in majority voting gives them a voice to influence decision-making. Despite the different perceptions of the participants about citizen participation, the following themes emerged as forms of stakeholder involvement.

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5.2.1.1 Voting for representatives in different positions of power

The perceptions of the participants indicated that one form of citizen participation is voting during elections. Most respondents perceived this as a sign of power for the people once the majority won, while others perceived it as a direct democratic decision.

The views of the respondents presented a clear picture of how citizens' participation is perceived. Some of the respondents (members of the community) explained their views as follows:

Nyasha, a 30 year old male community member said:

> *I see this as involving political behaviours and making your leaders accountable through voting mechanisms*,

Sharon aged 42, a third respondent said "*It refers to who is eligible to vote, what is decided by direct democracy*."

A fourth respondent, Max, aged 51, said: "*It's power in the hands of the majority*."

A fifth respondent Praise, a 57-year-old woman, said that, "*People have power to choose what they want".*

The notion of citizens' power has been supported by scholars like Arnstein. Citizen participation is power, according to Arnstein (1969). Some of the respondents emphasised that their voices are heard by voting for their preferred candidates and reserve the power to vote if they fail to deliver. Williams (2006) also recognises the need for citizens to participate fully in all forms of participation to claim full participation rights. It is only when people claim or demand power to achieve specific concrete goals such as implementing a specific plan, project or program that presence, participation and voice at the local level assume experiential meaning. This means that participants need to be aware of their ability to make judgments, how meaningful change can be made, and how to play political roles as a citizen (Williams, 2006). In Zimbabwe, voting takes place under the multiparty system, where citizens choose their preferred party leaders. Individuals are also allowed to vote for positions of power as independent candidates. Both councillors and parliamentary members selected through this

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process are responsible for making decisions on behalf of citizens in planning and policy making.

5.2.1.2Consultation of citizens through public gatherings

The participants' response also indicates that, through annual general meetings and community meetings, they perceive consultations with the public as a form of citizen participation where citizens raise concerns that affect their society. A majority of the respondents stressed that citizens should be consulted before they receive services. One of the members of the community, Praise, complained:

> *The majority of the community is not aware about when and where meetings are held regarding any health issues. For the few that attend, they are told about plans that are already in progress and if suggestions are stated, they are not heard and are taken as negative comments*.

The interviews with the councillors indicated that government programmes that were planned without local people's knowledge became a challenge to be implemented. The sister-in-charge (Sister Kadzunge) at Dangamvura polyclinic suggested that more community gatherings should be held at least once a month at a central location where everyone has an opportunity to attend. According to the data collected through questionnaires, eighty percent of the community members had a similar view to her because they also see the need for frequent interaction with health promoters, nurses, and their councillors to engage and participate more on improving PHC in their community. According to Schwartz and Deruyttere (1996), consulting means informing the other, meaning a community needs to be informed on why, how and where the new programme will be launched. The councillors further stressed that communities better understand the local terrain and can identify the unforeseen challenges. Bjorkman and Svensson (2009) indicate that involving communities in health programs improves the performance of health workers and subsequently the health conditions.

5.2.1.3 Taking part in health promotions and demanding better healthcare

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The response of the participants also indicated that several programs are perceived in communities as a form of participation and require the willingness of individuals to participate in such programs. Many programs are arranged in a non-selective manner, which means that all individuals in the community on board are invited to participate in their running. This is in line with one of the respondents' response about how he perceives citizen participation; "I think this is a process by which services are provided according to the needs of communities or where communities participate in making policies governing them in the process of service provision". Another community member said that "It refers to being active member of society and actively help in its restructuring". The participants emphasised that most of these programs call for every community's member's initiative, especially in health department when there is an outbreak of a deadly disease. James, a 28 year old Health Promoter responded by stressing that:

> *Some community members, especially the elderly, are less interested in participating in any health programs because they are unable to read and understand because most pamphlets are written in a small font and the language used is too advanced for them. They would need pamphlets written in Shona for a better understanding. The deaf and blind people also face communication challenges. Therefore, communication barriers can make somebody less interested and ignorant.*

According to WHO (2002) for health promotion to be successful, people must be involved in order to prevent, be part of preparations for and respond to threats that may occur in the community. Community participation is therefore the 'basis of successful health promotion.

5.2.2 Lack of open trust relationship

Gilson and Erasmus (2006) stated that "Trust is often the foundation for co-operation in pursuit of positive social outcomes. Its key characteristics may be summarised as integrity, benevolence and competence". The role of trust in service delivery (PHC services) is important and in community participation should not be underestimated. The theme of trust seems to surface strongly in the findings of this research as it became evident that community members do not feel they have an open relationship with PHC staff. Although the community members realise that they have that right to

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the freedom of speech, they are afraid to voice their opinion: “there are some certain issues that make the community not satisfied, but because of fear...we do not speak, whilst we do have the right to talk’. The other aspect mentioned was that there exist a communication breakdown between the community and the PHC services because of fear to participate and to rather complain to themselves: ‘…when they have to say something about the clinic, they do not speak out, like if they have complaints’. In a study conducted by Gilson and Erasmus (2006) on improving health services by building trust, a member of the health committee as a participant cited the following that summarizes the importance of building trust relationships between community members and health services: “I really understand that what we are looking at is the lives of our people…the reward would be the way our community is treated and the way our community feels about the services at the clinic”.

5.3 Platforms for interaction in efforts to improve Primary Health Care

5.3.1 Raising people’s voice through Public Hearings

The officials believe that listening to people’s views have made a great improvement in the participation in health programs. The officials pointed out that there are several channels used to raise awareness among communities, such as TV and radio shows and community gatherings. The local people raise their concerns in these community meetings with their representatives in the community, as well as with the heads of the social welfare committee. They stressed that the collaboration of leadership can also improve the performance of health promotion programs. However, an interview with one of the hospital administrators indicates that people rarely use the suggestion box because they feel that even if they do, no one will ever open and read it or even if they read it, nothing will change. A male community member Max, added that:

> *Even if community gatherings are held for health programs, the implementation process takes long and some ideas are just left redundant. Some council leaders care about the households around them and not the whole community so that they get votes and support for the next elections.*

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The clinic administrator pointed out that people believe that government services never change and it is the same reason why those with better background force their way to private hospitals in search for better services. “Local people who afford private clinics don’t even mind, most of them chose to go to private hospitals because they believe that public hospitals services never change” said Amanda, a patient from Save Clinic. The response from the beneficiaries indicates that people who go to private hospitals go there to get medication. They pointed out that even though patients are diagnosed in the public hospital, they are referred to private clinics to buy medication. The sister-in-charge (Sister Runoza) at Save Clinic confirmed that due to lack of vaccines at the clinic, babies are referred to Dangamvura polyclinic where vaccines are administered once a week.

On the other hand, the interview with one of the councillors indicates that people have platforms where they can lodge their complaints in contention to service delivery. She said that councillors and social welfare committee of the council are always open to listen to peoples complaints concerning service delivery. There are also public hearings that are once in a while arranged in communities for people to express their views to their representatives in the parliament and the district council.

5.3.2 Perceptions of community leaders on community participation in PHC services

The community plays different roles in the PHC services in community participation, namely a role in advisory, supporting, and service delivery through patient tracing and referral, as well as an educational role. They also perceive the need for formal PHC committees and the need for PHC services to enhance community involvement through certain basic principles, namely accessibility and equality, community-based and home-based approach with trust relationship between community and PHC services.

Community leaders expressed their views on current community involvement that collaborative cooperation between the existing clinical committee and the PHC clinic is vacuuming due to the lack of knowledge about the roles and functions of the existing clinical committee and the fact that clinical committees have lost their voice in the community. The community leaders add on a positive note that the PHC services

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empower the community through sharing of knowledge through workshops. They further believed that there is community participation through clinic committees, although they viewed clinic committees as ineffective, stating different reasons. The former mayor, Tatenda Nhamarare, expressed his perceptions on implementing of community participation, but stating that, "there is need for a formal communication platform between the community and the PHC services to ensure regular, continuous meetings between the community and the PHC clinic personnel to share expectations and give the opportunity for community to know the PHC clinic personnel. They further believe that re-engineering services should be strengthened as they are instrumental in community involvement and believed that this is possible through home-based care, including care for the chronically ill and the elderly with community leaders ' involvement". All councillors interviewed strongly agreed that there is a positive relationship between community participation and quality of PHC services provided and that community participation can enhance the quality of PHC services. Responses also highlighted that community participation can lead to shared responsibilities that can improve quality of PHC services, and that would cause a reduction in mortality and morbidity due to joint effort to tackle health problems and finally community participation can strengthen PHC outcomes therefore improving the quality of the community's health.

5.3.3 PHC services should enhance community participation through certain basic principles

The community members believed that the first principle is making PHC services more accessible and equal, as one participant stated:

> *People should go to the clinic freely...be free to participate in services.*

The Alma-Ata Declaration, which emphasises health 'as a fundamental human right' states that PHC should be accessible, affordable and socially relevant to meet the needs of the community (Aibinuomo, 2011). It is difficult, if not impossible, to separate PHC to community participation as community participation is component of PHC, therefore PHC should be accessible for effective community participation to occur (Lehmann, 2008). On the other hand, Swanepoel and De Beer (2011) believe that community participation should be equal. They urge that often the poorest of the poor do not get their fair share of community participation. The second basic principle

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identified was that community- and home-based approach contributes to effective community participation, as was stated:

There should be people who can help those people at their homes...

Another participant stressed community participation means people are consulted in their own homes, “If some members can go and consult...in his house?”

The concept of task shifting HIV treatment and care from PHC nurses to Community Health Care Workers was elaborated by World Health Organization (WHO) in 2004 as an immediate way to address shortage of staff while delivering good quality of care, as community-based care is economical and effective (Callaghan, Ford & Schneider, 2010).

Community members finally believed that trust and respect is important between community and PHC services for the effective community participation, they further believe that trust and respect should be two way process between the community and PHC personnel, “...when we go to the clinic we should show respect...respect one another...People should not be shouted at...”.

The principle of trust was stressed by the community members as they believed trust between the community and PHC personnel is essential for community participation, it was pointed out by another participant that, “...you should consult her and talk with her to find out if she will treat you as it was said...cooperation with the community so that we do not fear them.”

The literature supports the issue of respect by stating that for effective community participation there should be mutual respect between the community and PHC service, as if respect is compromised, trust is also compromised, affecting the effectiveness of community participation (Chung et al., 2012). The authors argued that Ideal community participation requires health personnel to engage in two-way communication and effectively share their power with the community based on mutual respect and trust as community participation suffers when there is a lack of trust because the community feel as if they are not listened to. Browns (2008) on the other hand believes that community participation is concerned with ensuring that community treated in mutually respectful way and is properly informed about negotiations concerning their health

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5.4 Stakeholder perceptions on the quality of service in Primary Health Care

5.4.1 Residents' Perceptions and Opinions on the State of Mutare City's Health Service Delivery

Tatenda, a male community member aged 32 had this to say about the state of Mutare city's health service delivery:

> *Mutare city health authorities have failed to address the continuing decline in service delivery. Even the rates they are charging are not correlating with the services being rendered to residents due to misplaced priorities and lack of strategic direction.*

This actually depicts that residents are worried and disappointed about the state of Mutare city's health service delivery for they think the city health authorities have failed to address their concerns.

A community member, Max, also commented that: "corruption, nepotism and lack of political will are slowly ruining the city although the city health authorities point at cash flows as the root cause of the problem." This clearly shows that Mutare city residents blame the city health authorities for poor health service delivery in the city accusing them of corruption.

Furthermore, another female respondent, Sharon, reiterated that: "liquidity crisis has resulted in city health authorities failing to treat water, to maintain roads, to purchase drugs, to pay staff and even to collect household refuse."

This clearly shows that liquidity crisis has affected various sectors of economic and social development within the city including the health sector. There are higher poverty levels among residents; poor health infrastructure; and inadequate and or uneven distribution of healthcare personnel which hinders delivery of quality services. It is sad to note that in the four public clinics in the city a maximum of two qualified nurses are always present and the rest are student nurses on attachment.

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This also depicts shortages of health personnel as well as shortage of health centres in the city. This is in support of Awiti (2014) who argued that given the scarcity of qualified health workforce in urban areas and the unfairness of their distribution, people prefer to seek health care from non-qualified providers in the informal sector, especially the poor and the disadvantaged.

In addition, Tatenda one of the community members commented: "The population influx places a lot of pressure on available sanitation facilities". This means that urban sanitation poses a great concern as Mutare city continues to move towards urbanisation". He further mourned that:

> *Our lives are in danger due to improper disposal of household waste as illegal dumpsites are found everywhere within residential areas which have become breeding sites for parasites like mosquitoes although the blame does not entirely fall on the city health authorities but to us residents as well since some of us deliberately ignore the health and safety rules both at workplaces, at public places and even in residential areas. Some of us have even accrued huge debts with the city council thereby crippling their resource base.*

This clearly shows that the residents are also to blame of poor health service delivery in Mutare city since some of them are not playing their part to ensure quality health service delivery in the city.

In addition, when asked about their perceptions, a 27 year old male, Boniface responded that:

> *Most employers are failing to remit money to medical aid [health insurance] societies as their companies are battling to continue to exist, and coupled with the high unemployment rate means a good fraction of the population suffer since they do not have cash to cover medical bills. As a result, the city's premature deaths are on the rise (both maternal, neonatal, and under-five mortality.*

This clearly shows that the majority of residents in Mutare do not have money to cover medical bills let alone to acquire drugs from pharmacies. This concurs with Mosadeghrad (2014) who indicated that it is mostly the urban poor who cannot afford tertiary care services to access health care.

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Boniface further added on the state of health service delivery in the city had this to say:

> *Effective health service delivery in the city is a project that requires very expensive solutions during a time of limited governmental assistance in terms of monetary resources since as a result of political and economic meltdown, almost all the city health authorities in the country are suffering from budget deficits and inadequate financial resources for development, general administration, service delivery and infrastructural maintenance.*

This clearly shows that health service quality has been declining for a very long time in the city and that residents fear this may become the order of the day for life.

5.4.2 Access to health care services

In this city there are very few specialist doctors and all those who need specialist services have to be referred to Parirenyatwa in Harare. Another problem is the failure to acquire drugs. People pay a $25 fee for cards at clinics but there are no drugs. The clinics just write a prescription and you are supposed to purchase the drugs from a pharmacy. Most people die because they do not have money'

This actually shows that the residents had problems in the payment of the medical fees even though they knew the dangers of lack of medical personnel and drugs. This is also in support of Mosadeghrad (2014), who argued that public hospitals in urban areas lack drugs while some may only have panado (a pain stop) in stock.

Naomi Muzandaka, a female nurse said this when asked about health service conditions in the city: "Although the local government constructed some clinics in the city, most of the structures are now white elephants due to lack of manpower and drugs." This actually shows that residents are being sent home without proper treatment at the clinics due to lack of medical supplies. This concurs with Dogba and Fournier (2009), who indicated that the subsequent devaluation of the national currency under SAP had devastating consequences on health service delivery since it made imports more expensive and thus creating serious supply shortages in pharmaceutical goods and other medical equipment

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5.4.3 Health Service Delivery Challenges in Dangamvura

5.4.3.1 Lack of Drugs

On health service delivery challenges one of the married male councillors, Mr Phiri interviewed noted:

> *Council and government clinics simply give patients prescriptions and then ask them to go and purchase the medicine and drugs at private pharmacies due to shortages of drugs. The fact that most of these private pharmacies charge exorbitant prices which most of the urban poor cannot afford means that many die prematurely.*

This actually shows that there are drug supply stock outs and shortages in the public clinics and that many patients cannot afford to purchase drugs from pharmacies

5.4.3.2 Emergent shortage of medicines

The country relies heavily on imports for drugs, equipment and other hospital consumables. The crippling foreign currency shortages have constrained such imports. Many wholesalers have temporarily stopped the importation of critical drugs such as ARVs, antibiotics, painkillers and drugs to treat non-communicable diseases owing to challenges in accessing foreign currency. The shortage of drugs has also led to an increase in the price of drugs by retailers. Some central hospitals have over the past months run out of critical drugs. Critical preventive drugs are not available in most healthcare centres, especially in the levels of dispensaries and government clinics. Owing to this problem, most patients only receive diagnostic services, but are left to search for pharmaceutical services from other places. This challenge was coupled by the fact that most individuals are poor, increases chances of mortality and morbidity. In addition to lack of drugs in most hospitals, there are no adequate facilities to carry out correct diagnosis on patients. Some vital equipment like x-ray machines, diagnostics ultrasounds, monitors among others are not available in most health facilities, with only a few being available in bigger hospitals.

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5.4.3.3 Lack of medical staff

Praise, a female respondent had this to say on health service delivery challenges:

> *Overall, the country has been losing healthcare professionals to neighbouring countries due to the country's economic challenges. This means that most of the experienced doctors left the country leaving young and inexperienced doctors at risk of public health.*

This also show that most public clinics are understaffed and thus cannot cope with the number of patients coming for medication and treatment and that those health personnel available are unable to deal with major illnesses. This concurs with Bakeera et al., (2009) who observed that the lower health care units in Uganda were mainly staffed by unskilled ward maids or dressers that formed 40% of the work force who are more often than not school dropouts that got trained on the job and are reported to run most of the lower unit levels because trained nurses were not available and that these people lack knowledge which is essential for designing a need based pro-poor health system.

Ms Hove, a female councillor, also had this to say on health service delivery challenges:

> *The country is still using the 1983 staff establishment when the population was about seven million. However, the population has since doubled and likewise the disease burden has also increased considerably. The problem is also exacerbated by low salaries received by health professionals which results in them engaging industrial strikes at the expense of patients. This has been witnessed recently as junior and middle-ranking doctors laid down their stethoscopes in protest against poor remunerations and pathetic working conditions characterised by absence of basic drugs and other tools of trade.*

This actually show that no health personnel have been recruited recently and that those employed are earning low wages which end up forcing them to engage in industrial strikes which has far reaching and devastating consequences as several people who could have survived will end up losing their lives. Furthermore, the sister-in-charge, Mrs Kadzunge, when asked about the health service delivery challenges had this to say: “Can you imagine, this whole city is being serviced by only two

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ambulances which in most cases either do not have fuel for emergency errands or have missing wheels." This clearly shows poor emergence responses within the city which result in patients dying of treatable diseases.

5.4.4 Other challenges that affect quality of services in Primary Health Care

5.4.4.1 Environment

As observed by the researcher, there were a number of health problems in the environment. While safe water and sanitation facilities are present in the city there is unreliable functioning, prolonged cuts leading to use of unsafe alternatives which undermine health, as well as waste disposed in open pits and public sites. This actually shows that residents have created their own dumpsites by the roadsides which become breeding grounds for parasites. On health service conditions in the city the researcher also observed that the public toilets at bus terminals, which are usually next to fruit and vegetable markets are rarely cleaned; and that street kids and the general citizenry simply dispose of litter anywhere and anyhow instead of disposing of it as it should be in the trash can or dustbin. This is in support of Booth et al (2014) who argued that the result would be reported higher urban diarrhoeal disease rates than in rural areas. Furthermore, the above observation was supported by Mr Phiri who mourned that: "the state of communal toilets in suburbs like Sakubva and Dangamvura is deplorable and they are not even in function which poses a health hazard to the residents." This is an unfortunate scenario as public toilets can by no means be avoided as nature calls are eminent thus putting everybody to a health risk as the toilets become infested with not only maggots but also intoxicating smell.

5.4.4.2 Nutrition

Mwanyara Jusa, a former councillor had the following to say on health service conditions: "we are facing challenges in meeting nutritional needs for ourselves and the children because of the current economic situation." This actually shows that some residents are going without proper nutrition and is in line with Nembhard et al., (2009) who reasoned that health service provision in many urban areas has been undermined

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by HIV/AIDS, poverty, economic decline, social inequalities as well as political discord and as a result, communities have experienced outbreaks of epidemics and declining service quality.

5.4.4.3 Distance

Mwanyara Jusa, when asked about the health service conditions in the city had this to say: "We have to commute to our nearest clinics which are more than 5km from our usual places of residence". This actually shows that clinics in the city are unevenly distributed and are few as compared to the entire populace. This concurs with Nembhard et al (2009) who argued that health care centres in many countries are far apart such that many people face difficulties in accessing them.

5.4.4.4 Water distribution

In addition, the researcher observed that water distribution equipment and the sewerage system in Mutare city has hardly ever been renovated or replaced since it was laid down and due to this limited maintenance of the sewerage system. Sewerage pipes have been continuously bursting, thereby contaminating some of the water sources that are being utilized by the residents confronted with water blues, thus exposing them to a number of related diseases. This was also supported by Tatenda, who had this to say on causes of the health service delivery challenges:

> *Most of the problems associated with bursting of sewer pipes emanate from the fact that existing amenities in this city were planned and laid down to accommodate smaller population demands, but however, the rapidly growing urban population has increased pressure on available amenities and resources.*

This clearly shows that while the urban population in Mutare city perpetually increases, there has not been any corresponding increase in the quantity and quality of public infrastructure and services.

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5.4.5 Efficiency of clinics in their service delivery

When asked about the efficiency of the local clinics and hospitals in their service delivery, Cindy Runoza had this to say:

Access to health here is really difficult. People are dying from curable diseases. Our clinics do not even have stop pains like paracetamols. All we are giving now are prescriptions but the general populace does not have money to buy the drugs at pharmacies. The rights to health in the constitution are only there on paper not for the entire population.

This shows that there is scarcity of drugs in public hospitals and clinics in Mutare. This is in line with Gakii (2013) who argued that many patients are going without proper treatment due to absence of drug stocks in public health centres. This also in support of Mosadeghrad (2014) who argued that drug and drug stock outs and shortages are also a characteristic of urban health systems in developing countries and this force people to prefer seeking care from higher level services at considerably greater distances, with higher costs to households and services.

In addition Dr Kudzai Murembwe had this to say when asked about efficiency of clinics:

> *All public clinics do not have doctors; they only have a few nurses most of whom are students on attachment, hence some of the illnesses and diseases are beyond their capacity to treat. The end result is that many patients are being sent back home without being treated while others are recommended for home based care. At the district and general hospitals where doctors are available, the doctor to patient ratio is frightening and in most cases the doctors cannot treat all the patients but attend only to the critically sick.*

This actually shows a shortage of health personnel in both public clinics and hospitals and thus those available cannot meet the high demand of patients seeking healthcare they meet on a daily basis.

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5.5 Strategies to improve the participation and involvement of stakeholders

5.5.1 E-Health services

E-Health is defined by the World Health Organisation as "the combined use of electronic communication and IT in the health sector". In more practical terms, E Health is the means to ensure that the right health information is provided in a secure, electronic form to the right person at the right place and time in order to optimize the quality and efficiency of delivery of health care. According to the National Health Strategy (2016-2020), key health tools and applications are:

- Electronic Medical Record Systems, to track individual patient records over time through the health care delivery system
- Mobile Health: This is the use of mobile devices in health delivery. The mobile tools include mobile phone technologies use in disease monitoring and reporting, mobile computing tools such as wireless laptops, and tablet computers that provide easier mobility that more localised devices. Key health related applications that can be used in mobile health include:
  - National disease surveillance and monitoring tools
  - Patient information repositories
  - Helpline
  - Education and training resources

Globally, all sectors are embracing Information and Communication Technologies to enhance service delivery and increase competitiveness. Sandra, a 16 year old female had stressed out her view say:

> *At times, one would need advice or recommendations if they are sick late at night and are not able to visit the clinic. If there is a doctor's online service or chat platform to do so, it makes it easy for one to connect to a doctor at their homes. Most teenagers are reluctant to visit clinics when they are not well unless they become serious. They may feel that they are going to be judged if nurses know their conditions. I am one of those who feel insecure when talking to a stranger about something sensitive.*

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If more people are linked to health programs on their mobile phones they are more updated and informed about and activities or meetings and workshop to be attended. The use of pamphlets and flyers can make one forget information. E-Health can also cater for the elderly, as they can have options to retrieve information in the language they prefer.

5.5.2. Accessible health facility

Community members in Dangamvura, especially in Ward 15 are not located near a health facility and this is a major concern because they cannot easily access health assistance. Nyasha, a 30 year old male community member, stated that:

> *Most people who reside in Ward 15 are informal and sanitation is their biggest challenge. There is also limited water supply and electricity. When people get sick they either stay in their homes hoping to get better or walk a long distance to the clinic or the main road to get local taxis to the clinic if they have the money.*

More health facilities are required to ensure that people have access to treat when needed. The government has the responsibility to ensure that citizens have health care as it is their right. Building more clinics in Dangamvura is strategy that could improve stakeholder participation. Sandra, an 18 year old female had the following to say:

> *In most cases, community members do not see the need to attend any health programs or participate in health drives or campaigns because they are bitter from not seeing any improvements done to Primary Health Care. For those willing, distance is a major factor and it makes participation less constant.*

5.5.3 A balance between PHC and Political Agenda

The community leaders who are the councillors are elected within political parties. When an NGO comes to Dangamvura to assist in health care or a health campaign is being planned by the clinic, counsellors are informed in order to give permission or for them to be informed. The clinics can use political gathering to address the community on health issues which is easier as they are guaranteed to have a good attendance. But on the other hand this may have a negative impact at some cases. The Former Mayor, Mr T. Nhamarare had the following to say:

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If a Councillor gathers people for a health issue concerning the community members, only those in his political party will attend and those who are not, will not attend as they will think that it is related to politics. Some NGOs prefer working with the assistance of health promoters and nurses to avoid any political attachment to their cause.

The use of neutral representatives is a good strategy to use in order for all community members and leaders to attend.

5.5.4 Permanent Skilled Staff

Dangamvura polyclinic and SAVE clinic in Dangamvura currently have a doctor that visits these clinics at certain days for a specific time. If it is an emergency, they go to the clinics and assist. Sisters-in-charge are responsible for the day-to-day duties at the clinics. A permanent doctor is required to always be available to assist people without having to wait for them to arrive. More doctors and nurses should be employed at Dangamvura. Amanda, a 26 year old female stated that, “nurses overwork due to the amount of patients that come for assistance”. On this point, the Sister-in-Charge also agreed that they are understaffed. She also added that:

If there were other medical facilities available, more nurses will be employed and the ratio of nurses to patients will be manageable. More nurse can be allocated for home visits to assist those who are critically ill and cannot go to the clinic, and others can be sent to attend workshops or gatherings in efforts to encourage and educate community members to be more alert when it comes to health issues.

5.6 Chapter summary

The discussion of the research findings on the perceptions of the community members regarding their participation in PHC services rendered followed and was confirmed against existing literature concerning community participation in PHC. The findings of this research included different themes and sub-themes that were integrated with relevant existing literature for confirmation, followed by concluding statements. Chapter 6 deals with a discussion of the conclusions by the researcher, evaluation of the research, limitations and recommendations.

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Chapter 6: Conclusion and Recommendations on the impact of promoting stakeholder participation in PHC.

6.1 Introduction

The study sought to establish the impact of promoting stakeholder participation to improve Primary Health Care and this chapter serves to conclude the study. Implementing the recommendations outlined in this chapter will involve interactions with diverse stakeholders in all levels of decision making. Many of the proposed actions for participation and accountability raised by communities called for strengthened joint mechanisms concerning civic and elected leaders and health providers with clear terms of reference, roles and authorities and sufficient training and resources for their functioning. There is almost universal agreement of the positive contribution of stakeholder participation in health, and of the need for it to be supported and enhanced. To do this there is a need for more than simple activity from communities, but a deeper process of empowerment to take control and initiative on health problems. The chapter provides conclusions of the study and recommendations derived from the findings.

6.2 Discussion

6.2.1 Lack of understanding and appreciation by stakeholders of socioeconomic issues and technical processes involved in the visioning processes.

Stakeholders in Dangamvura are not empowered with information and skills to appreciate and act on the complexities of resources determination, allocation and prioritisation processes. Strategic planning and management processes are by their very nature complex processes that are undertaken by people with appropriate levels of technical and management skills. Setting resources aside to facilitate and empower

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stakeholders would enhance the strategic planning and management processes greatly, thereby legitimizing any decisions taken. Very little resources are made available for empowering stakeholders and fa

cilitating the engagement in the strategic planning and management processes in health care. Lack of financial viability might be contributing to lack of funds to empower stakeholders and facilitate planning processes. The fact of the matter is that the majority of people do not have the level of education required to understand strategic planning and management processes.

6.2.2 Information is not disseminated timeously and widely

Dissemination of information at Dangamvura for strategic planning and management purposes is neither done timeously and widely nor is it packaged in a manner that facilitates stakeholder involvement in the planning process. Where information is disseminated it does not reach all the intended recipients because of challenges around access. The packaging of information to targeted recipients is also a challenge as it is mainly in English and for the majority of stakeholders such information would require translating further into local languages for ease of comprehension. Information session meetings that are held, have been found to be far and few in between with very unsatisfactory attendances. Poor effort on the part of the Dangamvura Council regarding provision of information to stakeholders is linked to the absence of a public participation strategy which could have identified information needs of the various stakeholders and provided accordingly for that.

6.2.3 Building healthy public policy

Healthy public policy, a key health promotion strategy, reflects the role of government and the public sector in establishing health-supporting circumstances (WHO 1988; Tones & Green 2004): the primary objective is to build a supportive atmosphere for individuals to lead good life (WHO 1988). The significance of this approach has been emphasized many times (e.g., WHO 1988, 2005; Wismar et al. 2006; Jackson et al. 2006): such a policy defines the atmosphere that makes possible the other approaches (WHO 1988; Jackson et al. 2006). In addition, latest overviews of health promotion policies highlight the vital role of political engagement to health promotion growth (Scriven & Speller 2007) and its efficiency (Jackson et al. 2006). In other words, health should be at the top of Zimbabwe's policymakers ' agenda.

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Apart from the wide determinants of the role of health and local government in this regard, another policy problem concerns the opportunities of people to regulate the

determinants of health as far as possible, that is, the key principle of community involvement and empowerment in health promotion. Community participation is considered crucial to the concept of a healthy public policy according to the National Health Strategy for Zimbabwe (2016-2020). It is particularly crucial at local level, according to ZIMFACT (2018), given that the information and views of people are crucial in shaping good public policies. As Zakus and Lysack (1998) point out, to be effective and long-lasting at the local level, community participation must be supported by the political and administrative system.

6.3 Conclusion

6.3.1 Government must address the key health determinants related to poverty and poor living conditions.

The country has been facing structural economic challenges, rising incidence of poverty, food insecurity, rising informality, increasing unemployment and underemployment negatively affecting health outcomes. These factors have to be addressed in order to improve the conditions of health and development. It is particularly important to broaden the tax base by dealing with the problem of informality (High growth and efficient tax system). The overall level of economic development is a key factor in determining the options for expanding health care coverage. The country must reaffirm its commitment to the values and principles of primary health care (PHC) namely: equity, solidarity, social justice, universal access and community participation.

6.3.2 Lessons learnt from Brazil and Cuba

Based on the research findings from Cuba and Brazil, Zimbabwe could improve their health care and stakeholder participation by the following:

- A focus on prevention and the social, economic and environmental determinants of health disparities.
- Equitable access to worldwide health services
- Investment in medical training

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6.4 Recommendations

6.4.2 Monitor health status to identify and solve community health problems

The following were also recommended by the Dangamvura community to assist in reviving health within their community:

- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate, and empower people about health issues starting from schools and church gatherings.
- Mobilise community partnerships and action to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Ensure competent public and personal health care workforces.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services and lastly research for new insights and innovative solutions to health problems.

6.4.3 Promotion of partnerships with the private sector

Capacity of the private sector, including NGOs is not fully being mobilised. It is important that the private sector be more involved in both supply of health services (including developing hospitals, clinics, diagnostic centres, education institutions, etc.) and demand for health services. The participation of the private sector in the health sector will help to bridge the huge resource deficit and provide state-of-the-art equipment at public health institutions. Chitungwiza Hospital is a good case study of an institution that has adopted the Public Private Partnerships (PPPs) strategy as a way of raising capital and ensuring state-of-the-art equipment. This has resulted in a significant improvement in service delivery. Consequently, Chitungiwiza Hospital became the first public hospital in Southern Africa to achieve ISO certification. There

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is however need for a strong regulatory and governance framework governing PPPS in the health sector.

6.4.4 Translate technical processes and jargon into layman's terms and local language respectively

Information is an important currency of exchange where there is a network of relationship amongst and between various role players such community leaders and members. Provision of information enhances openness and transparency thereby building trust amongst the various network players. It is therefore very important that information of the Primary Health Care processes be made available to all stakeholders for their meaningful participation.

Not only should information be made available but it should be packaged in such a manner that it is capable of being used and for an average person that means some of the complex technical processes need to be simplified and the English language in which the documents are written translated into local languages for ease of comprehension. This might be a very costly exercise but the important thing is that people can understand what is being discussed and decided upon and be part of those processes.

6.4 Recommendations for PHC services

Recommendations are provided to implement effective community participation in PHC services, which will improve the quality of health care services provided.

- PHC policy makers at district, provisional and national levels need to prioritise community participation policies and guidelines as areas that constitutes national core standards evaluation based on which PHC services are evaluated.
- Community participation should form part of quality improvement project for PHC service and also monitored to ensure it is implemented effectively.
- Community participation through clinic working groups should be improved by formulating and adhering to guidelines that allow clinic committee to form and be part of the PHC clinic. The guidelines hence should direct the clinic committee on how to represent community meetings and also providing feedback to the community.

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- Guidelines formulation can ensure effective participation of community leaders in the PHC. These guidelines should include areas on how to integrate PHC services with traditional health services and how the recommended system should be implemented.
- Health dialogues involving the community should form part of community participation, which means information should not be limited to PHC facilities, but should be communicated in public places and even in the media.
- The community members and the PHC services should depend on meeting regularly and discuss best possible ways to implemented community participation. In addition, all the recommendations should be implemented and feedback should be given to the community on a regular basis.

6.5 Limitations of the study

The discussions of the limitations of the research as experienced and observed by the researcher in the course of this research is as follows:

- During data collection, some of the research participants that were interviewed were reluctant to give information at first because they were afraid to be implicated even after they had read their confidentiality rights. It took time for them to relax and understand that the interviews were for academic purpose. Some of the questions asked at the beginning of the research were later referred back by the participants to answer them in detail.
- Politics in Zimbabwe plays a major role on how things are run in the communities. Research participants assumed that the research had a political agenda attached to the research so some of the questionnaires that were answered were biased. Instead of answering the question based on the current situation in health, research participants responded with answers that blamed political party leaders for the down fall of health care.
- Appointments were made with participants who were interviewed but half of them could not meet the agreed scheduled time and date so this delayed the data collection period. Two of the participants cancelled their appointed due to work commitments

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6.6 Chapter summary

The overall aim of the research is to propose recommendations applicable to PHC services, health education and health research on community participation in PHC services to improve the quality of health care. The objective was to establish the impact of promoting stakeholder participation in Primary Health Care in Dangamvura Township. Community perceptions were explored and described based on the data given by the participants, and main themes and sub-themes emerged. This research finding and recommendations will contribute to the promotion of community participation in PHC services.

The chapter ends the research with recommendations formulated for the government, the private sector and the PHC services to improve community participation in Dangamvura, Manicaland Province.

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References

Acheampong, K. O. 2011. *The tourism sector, development policy and inequalities in the development of the Eastern cape*, Unpublished Dlit et Phil. Thesis. Department of Geography. Pretoria: University of South Africa

ADB (2014). *Asian Development Outlook 2014 Fiscal Policy for Inclusive Growth*.

Aibinuomo, F.O. (2011). Primary health care (PHC) as the bedrock of the MDGs: community sensitization, mobilization and education on communication for positive health change. *IFE PsychologIA*, *19(*1*)*:529-542.

Akintola, O. (2006). Gendered home-based care in South Africa: more trouble for the troubled*. African journal of AIDS research*, *5(*3*)*:207-293

Annett H, Nickson P (1991). Community involvement in healdi: Why is it necessary? *Tropical Doctor 21*: 3-5.

Arantes, LJ, Shimizu ,H.E, Merchán-Hamann,E. (2016). The benefits and challenges of the Family Health Strategy in Brazilian Primary Health care: a literature review. *21*.

Arnstein, S. R. (1969) A ladder of citizen participation. *Journal of the American Institute of Planners, 35*(4), 216-224.

Babbie, E. and Mouton, J. 2007. *The practice of social research*: South African edition. Oxford: University Press

Bakeera. S.K., Wamala, S.P., Galea, S., State, A. Peterson, S. & Pariyo, G.W. (2009). Community perceptions and factors influencing utilization of health services in Uganda. *International Journal for Equity in Health 8:25*. doi: 10.1186/1475-9276-8-25.

Barreto, M. L., Teixeira, M. G., Bastos, F. I., Ximenes, R. A. A., et al. (2011). Successes and failures in the control of infectious diseases in Brazil: social and environmental context, policies, interventions, and research needs. Lancet, 377(9780), 1877–1889.

Barrett, B., Marchand L., Scheder J., et al. (2003). Themes of holism, empowerment, access, and legitimacy define complementary, alternative, and integrative medicine in relation to conventional biomedicine. *Journal of Medicine, 9*, 937-947.

© University of Pretoria

Bassett, M., Bijlmakers, L. and Sanders,D. (1997): Professionalism, patient satisfaction and quality of health care:experience during Zimbabwe's structural adjustment programme. *Social Science and Medicine 45* (12):1845-1852.

Besley, T. & Ghatak, M. (2007). Reforming Public Service Delivery. *Journal of African Economies, 16*, AERC Supplement 1, pp. 127–156

Booth, M. Martin, K. Lankester, T. (2014). *Urban Health and Development: A Practical Manual for use in developing countries*. Oxford, Macmillan Education.

Bossert TJ, Larranaga O, Giedion U, Arbelaez JJ, Bowser DM. Decentralization and equity of resource allocation: evidence from Colombia and Chile. Bulletin of the World Health Organization. 2003; 81(2): 95-100.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', Qualitative Research in Psychology, pp. 77–101.

Brinkerhoff, D. January (2003). *Accountability and Health Systems: Overview, Framework, and Strategies. Bethesda*, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Bryman, A. & Bell, E. (2003). *Business research methods*. Oxford: Oxford University Press

Burns, N. and Grove, S.K. (2011). *Understanding Nursing Research: Building an Evidence Based Practice*. Saunders: Elsevier

Callaghan, M., Ford, N. & Schneider, H. (2010). A systematic review of taskshifting for HIV treatment and care in Africa. *Human resource for health, 8*(8):1-9.

Chadambuka, A., Chimusoro, A., Tsitsilina, A., Tshimanga, M., Namusisi, O. and Luman, E. 2012. The need for innovative strategies to improve immunisation services in rural Zimbabwe. *Disasters, 36* (1): 160–173

Chikwature, W & Chikwature, E. (2019). Health Service Delivery Complexities in Mutare Urban, Manicaland Zimbabwe. Available online, https://cirworld.com/index.php/jssr.

Christiansen, Isaac Zvi. (2010).Improving public health care: an examination of the nature of Cuban government assistance to the Ghanaian public health care system

© University of Pretoria

.Graduate Theses and Dissertations. 11337. Available online, https://lib.dr.iastate.edu/etd/11337.

Chung, P., Grogan, M. & Jennifer, M.E. (2012). Residents' perception of effective community rep Russel, M. & Schneider, H. 2000. Rapid appraisal of community-based HIV/AIDS and support programs in South Africa. Durban: Health System Trust. . *Social science and medicine*. *74*(10):1652-1659.

Constitution of Zimbabwe Amendment (No. 20) Act, 2013. Available at: https://www.refworld.org/docid/51ed090f4.html [accessed 26 February 2019]

Cortez, LR. (2019).The retention of physicians to primary health care in Brazil: motivation and limitations from a qualitative perspective. Available online: https://doi.org/10.1186/s12913-018-3813-3 . [Accessed 30 January 2019]

Dennil, K.K.L. & Swanepol, T. (1998). *Aspects of primary health care: Community health care in Southern Africa*. Cape Town, Southern Africa: Oxford University Press.

Dennill, K., & Rendall-Mkosi, K. (2012). *Primary health care in Southern Africa: a comprehensive approach*. 4th edition. Cape Town: Oxford University.

Dogba, M. and Fournier, P. (2009). Human resources and the quality of emergency obstetric care in developing countries: a systematic review of the literature. *Human Resource Health, 7*, 7-21.

Donaldson, R.J. & Donaldson, L.J. (1994). Essential public health medicine. Lancaster, UK: Kluwer.

Dresang, L. T., Brebrick, L., Murray, D., Shallue, A., & Sullivan-Vedder, L. (2005). Family medicine in Cuba: Community-oriented primary care and complementary and alternative medicine. *Journal of the American board of family medicine, 18*, 297-303.

Dujardin B (1994). Health and human rights: The challenge for developing countries. *Social Science and Medicine 39*: 1261-74.

Eboreime EA, Abimbola S, Obi FA et al. (2017). Evaluating the sub-national fidelity of national initiatives in decentralized health systems: integrated primary health care governance in Nigeria. *BMC Health Service Res,17*(1): 227

© University of Pretoria

Epstein, H. (2008). The invisible cure: Africa, the West and the fight against AIDS. London: Penguin.

Fausto, A. (2017). Evaluation of Brazilian Primary Health Care from the Perspective of the Users. 40(2).

Feinsilver, J (2010). *Cuba's Health Politics at Home and Abroad*. The Socialist Register. London: Merlin Press. Forthcoming.

Fitz, D. (2012). *Why is Cuba's health care system the best model of poor countries?* Retrieved from http://mrzine.monthlyreview.org/2012/fitz071212.html.

Foster G (1982). *Community development and primary health care*: Their conceptual similarities. Medical Anthropology, Summer, 183-95.

Gakii, J. (2013). *Demand for Health Care in Kenya: The Effect of Health Insurance. Nairob*i. Kenya Institute for Public Policy Research and Analysis.

Government of Zimbabwe. (2013). *Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset): Towards an Empowered Society and a Growing Economy*; October 2013- December 2018.

Green R (1991). Politics, power and poverty: Health for all in 2000 in the third world? *Social Science and Medicine 32*: 745-55.

Grit K, van de Bovenkamp H, Bal R (2008). De positie van de zorggebruiker in een veranderend stelsel [The position of the health consumer in a changing system]. Rotterdam: Instituut Beleid en Management Gezondheidszorg.

Hair, J. F. Jr., Babin B., Money A. H. & Samouel, P. (2003). *Essentials of business research methods*. John Wiley: USA.

Holzemer, W.L. 2010*. Improving health through nursing research*. Geneva: Blackwell.

Invest in advocacy. *Community participation in accountability is key to ending the AIDS epidemic*. Geneva: Joint United Nations Programme on HIV/AIDS; 2016.

Kath, E. (2010). *Social relations and the Cuban health miracle*. New Brunswick, NJ: Transaction Publishers.

© University of Pretoria

Kautzky, K. & Tollman, S. M. (2009). *A perspective on primary health care in South Africa*. South Africa: Health systems trust.

Keck, W. & Reed, G.A. (2012). The curious case of Cuba. *American Journal of Public Health, 102*(8), 13-22.

Lehmann, U. (2008). *Strengthening human resources for primary health care*. http://www.hst.org.za/uploads/files/chap11_08. pdf. Date of access: 10 April 2019.

Loewenson R (1986) "Labour Security and Health", paper presented to the IAEA Regional Meeting, Nairobi.

Loewenson R and Sanders D (1988) *The Political Economy of Health and Nutrition* in C Stoneman (ed), Zimbabwe's Prospects, Macmillan, London: Macmillan, 133-152.

Loewenson, R. and Chisvo, M. (1994): *Transforming social development: the experience of Zimbabwe*, UNICEF, Harare.

Mackian, S. (2000). Contours of Coping: Mapping the subject world of long-term illness, Health and Place, 6: 95-104.

Magawa, R. (2012). Primary health care implementation: A brief review. Retrieved from http://www.consultancyafrica.com/index.php?option=com_content&view=article&id=1096:primary-health-care-implementation-a-brief-review-&catid=61:hiv-aidsdiscussion-papers&Itemid=268

Magnussen, L., Ehiri, J., & Jolly, P. (2004). Comprehensive versus selective primary health care: Lessons for global health policy. Health affairs, 23(3), 167-176.

Mahundi, P. (2015). *Journal of International Academic Research for Multidisciplinary. 3*(1). Great Zimbabwe University, Zimbabwe.

Mason, S.E., Strug, D.L., & Beder, J. (2010) Community health care in Cuba. Chicago, Illinois:Lyceum Books, Inc

Massuda, A, (2018). *The Brazilian health system at crossroads: progress, crisis and resilience.* 3(4)

Masuka N & Ray S.C, (2017). *Facilitators and barriers to effective primary health care in Zimbabwe*. https://doi.org/ 10.4102/phcfm.v9i1.1639.

© University of Pretoria

Ministry of Health and Child Care. The National Health Strategy for Zimbabwe 2016-2020. Equity and quality in health: Leaving no one behind. Harare

Ministry of Health. Planning for Equity in Health. A Sectoral Review and Policy Statement. Government of Zimbabwe, Harare, 1984.

Mogensen H, Ngulube T. (2001). Whose ownership? Which stakes? Communities and health workers participating in the Zambian health reform. Urban Anthropology 30: 1–34.

MOHCC (2016) Report on the costing of the Zimbabwe National Health Sector Strategic Plan 2016-2020

MoHCW (Ministry of Health and Child Welfare, Zimbabwe) (1997): National Health Strategy for Zimbabwe,1997-2007, Ministry of Health and Child Welfare, Harare.

MoHCW (Ministry of Health, Zimbabwe) (1984): Planning for Equity in Health, Government Printers, Harare.

MoHCW. (2010b). National Child Survival Strategy 2010-2015. Harare: MoHCW

Mosadeghrad A. M (2014) Factors influencing healthcare service quality Iran: School of Public Health, Tehran University of Medical Sciences. Available at http://ijhpm.com *International Journal Health Policy Management, 3*(2), 77–89.

Mpofu, A and Nyahoda, P. (2008). *National health financing in Zimbabwe 2005*. Contribution of the National AIDS levy to National health care support'. EQUINET Discussion Paper Series 54. EQUINET: Harare.

Mugwagwa JT, Chinyadza JK, Banda G. (2017). Private Sector Participation in Health Care in Zimbabwe: What's the Value-Added? Vol. 2 No. 2: 10. Available in: <http://healthcare-communications.imedpub.com/archive.php> [Accessed 19 April 2018].

Muller, M.E. (1996). Quality improvement in health care - a fundamental analysis and South African perspective. Curationis, 19 (4).

Mutizwa-Mangiza, D. (1997): *The opinions of health and water service users in Zimbabwe experience,* in University of Birmingham series The Role of Government in Adjusting Economies Paper 24, UK, November 1997.

© University of Pretoria

Nembhard, I. M., Alexander, J. A., Hoff, T. J. and Ramanujam R. (2009). Why does the quality of health care continue to lag? Insights from management research. *Academy of Management Perspectives, 23*(1):24–42.

Nichter M (1984). Project community diagnosis: Participatory research as a first step toward community involvement in primary health care. Social Science and Medicine 19: 237-52.

Nyamukapa C, Melegaro A, Del Fava E,Poletti P, Merler S, Williams J, et al .(2017). Social Contact Structures and Time Use Patterns in the Manicaland Province of Zimbabwe. 12(1). Graduate School of Medicine, Japana.

Nyazema, Z. (2010). The Zimbabwe Crisis and the Provision of Social Services: Health and Education. *Journal of Developing Societies, 26* (2): 233–261.

Nyoni, T & Bonga,W.J .(2017). Population Growth in Zimbabwe: A Threat to Economic Development? *Journal of Economics and Finance (DRJ-JEF),*2(6),pp29-39.

Paim, J., Travassos, C., Almeida, C., Bahia, L., et al. (2011). The Brazilian health system: history, advances, and challenges. The Lancet, 377(9779), 1778–1797

Phute, T. (2016*). Social Accountability and citizen engagement – understanding poor service delivery in the Zimbabwean context*. Available Online:<copsam.com/wp-content/uploads/2016/03/Zimbabwe-context_SAM.pdf>. [Accessed 08/05/2018].

Piot P, Bartos M, Ghys P, Walker N, Schwartlander B. The global impact of HIV/AIDS. Nature. 2015:410(6831): 968-73.

Reed, G.A. & Frank M. (2000). Cuba's thirty-year track record in community-based health care. Medicine review.

Reichenheim, M. E., de Souza, E. R., Moraes, C. L., de Mello Jorge, M. H. P., et al. (2011). Violence and injuries in Brazil: the effect, progress made, and challenges ahead. *The Lancet, 377*(9781), 1962–1975

Rifkin, S.B; Muller, F & Bichmann, W 1988: Primary health care on measuring participation. *Social Science & Medicine. 26*:931-940.

© University of Pretoria

Rohrer K, Rajan D.(2016). *Population consultation on needs and expectations*. In: Schmets G, Rajan D, Kadandale S, editors. Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization.

Rusa, L., & Fritsche, G. (2007). Rwanda: Performance Based Financing in Health. 2nd edition MfDR Principles in Action. Source book on emerging good practices.

Russel, M. & Schneider, H. (2000). Rapid appraisal of community-based HIV/AIDS and support programs in South Africa. Durban: Health System Trust. http://www.hst.org.za/publications/rapid-appraisal-community-basedhivaids-care-and-support-programs-south-africa Date of access: 14 July 2014

Schaffer R (1991). Balanced participation in development. *Tropical Doctor 21*: 73-5.

Schedler, A. (1999). *Conceptualizing Accountability*. In The Self-Restraining State: Power and Accountability in New Democracies, edited by Andreas Schedler, Larry Diamond, and Marc F. Plattner, 13–29. Boulder, CO: Lynne Rienner.

Schmidt, M. I., Duncan, B. B., Azevedo e Silva, G., Menezes, A. M., et al. (2011). *Chronic non-communicable diseases in Brazil: burden and current challenges*. Lancet, 377(9781), 1949–1961.

Schunselaar,J. (2011*). Making use of stakeholders in the healthcare sector*. Tilburg University.

Schwartz, N. & Deruyttere, A. (1996) *Community Consultation, Sustainable Development and the Inter-American Development Bank*. A Concept Paper March 26, No. IND-101. Press: Washington D.C. Online at http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.195.3877&rep=rep1&type=pdf. [Accessed on 15 April 2019]

Scriven A, Speller V (2007) Global issues and challenges beyond Ottawa: the way forward. Promotion & Education 14:194-8

Shamu, S. Loewenson, R., Machemedza, R. and Mabika, A. (2010). Capital flows through medical societies in Zimbabwe"s health sector. Equinet. Discussion Paper Series 82. Training and Research Support Centre, SEATINI, Rhodes University, EQUINET: Harare.

© University of Pretoria

Shilts R. (1987). *And the band played on. Politics, people, and the AIDS epidemic.* New York: St Martin's Press.

Shivambu,F. (2018). Notes from Havana: Healthcare – Lessons for South Africa. Available online: https://www.dailymaverick.co.za/opinionista/2018-09-21-notes-from-havana-healthcare-lessons-for-south-africa/.[Accessed 26 February 2019]

Swanepoel, H. & de Beer, F. (2011). *Community development: Breading the cycle of porvety.* 5th edition. Cape Town: Juta.

Szreter, S. (1997). *Economic growth, disruption, deprivation, disease, and death: On the importance of the politics of public health for development*. Population and development review, 23(4), 693-728.

Terre Blanche, M, Durrheim, K. & Painter, D. (2006). *Research in practice: applied methods for the social sciences.* UCT: Cape Town

The National Health Strategy for Zimbabwe 2016-2012. Equity and Quality in Health: Leaving no one behind. Zimbabwe.

Tones K, Green J (2004) Health promotion. Planning and strategies. Sage Publications, London.

Trappenburg M (2005). Gezondheidszorg en democratie [Health care and democracy]. Rotterdam: Erasmus University.

Trochim, W. (2002). Introduction to design. Available from http://scholar.google.com/ scholar?q= Trochim+W.2002%2Bintroduction+to +design&hl=en&as_sdt=0&as_ vis=1&oi=scholart. Accessed 1 May 2018

Tsiko, S. (2017, February 14). Zim must prioritise primary healthcare access. The Herald.

Ventres, W., & Hale, F. (1993). Community-oriented primary care: the Cuban plan. JAMA, 270, 1548.

Victora, C. G., Barreto, M. L., do Carmo Leal, M., Monteiro, C. A., et al. (2011). *Health conditions and health-policy innovations in Brazil: the way forward.* Lancet, 377(9782), 2042– 2053

© University of Pretoria

Wheeler, D and Sillanpaa, M (1998) *Including the Stakeholders: The Business Case, Long Range Planning 31* (2), p 201-210, Elsevier Science Ltd.

Whiteford, L. M., & Branch, L. G. (2008). *Primary health care in Cuba: The other revolution*. Plymouth, UK: Rowman & Littlefield Publishers, INC.

Whitehead M (1992). The concepts and principles of equity and health. International *Journal of Health Services 22*: 429-45

WHO (1991). Community involvement in health development: Changing health services. (WHO Technical Report Series 809.) Geneva: WHO.

WHO (2008). Cuba's primary health care revolution:30 years on. 85(5). Geneva.

WHO (2015). Fiscal Policies for Diet and Prevention of Non-communicable Diseases. Technical Meeting Report, 5-6 May 2015, Geneva, Switzerland

Williams J, J. (2008). *The politics of social change and the transition to democratic governance: Community participation in post-apartheid South Africa*. In African politics: Beyond the third wave of democratisation. Press: Cape Town South Africa.

Woelk G (1992). Cultural and structural influences in the creation of and participation in community health programmes. *Social Science and Medicine 35:* 419-24.

World Bank (2015). Data [online database]. Washington DC: World Bank. http://data.worldbank.org, accessed 14 December 2018

World Data Bank. (2014) Life expectancy at birth, total (years). Retrieved from http://data.worldbank.org/indicator/SP.DYN.LE00.IN

World Health Organisation (1994) A Review of Determinants of Hospital Performance, Geneva: WHO

World Health Organisation. 2018. A Vision for Primary Health Care in The 21ST Century. Geneva: WHO

World Health Organization (2014). WHO Health for All database (April 2014 edn). WHO Regional Office for Europe.

World Health Organization (WHO) (1988) Adelaide recommendations on healthy public policy. WHO, Geneva.

© University of Pretoria

World Health Organization (1974): Expert committee on community health nursing report of WHO expert committee. Technical Report Series 558. Geneva: WHO

Zakus JDL, Lysack CL (1998) Revisiting Community Participation. Health Policy and Planning 13:1-12.

Zikmund, W. G. (2003). Business research methods (7th ed.). OHIO: South Western

Zimbabwe Services Availability and Readiness Survey (2015).

ZIMFACT. Zimbabwe’s health delivery system. 15 March 2018

ZIMSTATS (2017). Quarterly Digest of Statistics: Government Printers, Harare.

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Annexures

Academic Research Information and Consent Form

Researcher:	Michelle Rutendo Tsonga
Contact details:	+27747389690 mimztsonga@gmail.com
Title:	What is the Impact of promoting stakeholder participation to improve Primary Health Care: A case study of Dangamvura Ward 7 & 15, Mutare, Zimbabwe

Nature and Purpose of Study

Primary health care (PHC) represents both a qualitative and a quantitative change in health care, both improving access to high risk groups, such as women and children, as well as emphasising to a greater degree community involvement and preventive and promote care (Trochim, 2002). The problem in Dangamvura for the past decade has been rapid population growth (RPG). This is a term used to describe an over - population state in terms of existing resource, in this case health resource (Charlot, 2012). More people are settling in Dangamvura leading to the development of more informal settlements. Because of a shortage of skilled professionals, lack of essential drugs and commodities, the township's polyclinic and private clinic cannot facilitate the entire community. Old, outdated and non - functional medical equipment is critical for diagnosis and treatment (National Health Strategy 2016 - 2020). With over population, the community becomes

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vulnerable for diseases caused by poor sanitation and lack of water supply. Distance to clinics also determines whether primary health care is going to be accessed. This study aims to analyse the impact of promoting stakeholder participation in Dangamvura Ward 7 & 15's quality of service delivery in primary health care. The study will evaluate how different stakeholders in a rapidly growing community can work together to increase awareness of health care and accessibility.

Data Collection

Data collection involves the collection of data relevant to the research purpose, according to Burns and Grove (2011). The actual steps in the collection of data are specific to each study and depend on the design and measurement methods of research. Research data will be sourced from both primary and secondary sources. I will review my secondary literature by using academic literature, reports, media articles and Mutare City Council records. I will draw on this literature selectively by extracting study - specific material from a wider range of subjects. I will use key informant interviews from medical staff, community leaders and members as a strategy of obtaining primary data. Questionnaires will also be used in this study and will be administered to twenty community members, who most of them are patients at Dangamvura Polyclinic.

Hair, Babin, Money and Samouel (2003) describe a questionnaire as a predetermined set of questions designed to capture data from respondents. For the purpose of this study the questionnaire will have closed and open ended questions. My focus on health practitioners, the community and their relationship with different stakeholders requires an understanding of the relationship's nature and interaction. It will be invaluable to have insight from some key individual with experience, interest and knowledge of these dynamics. I will conduct approximately 18 targeted key informant interviews with doctors, nurses, and general staff members at health centres, the counsellors and patients and others who may be interested in my area of inquiry. My interview questions will be structured and specifically designed for the field of expertise of the participant and will enable the participant to address a wide range of issues. As a measure of control, an interview schedule will be used to guide the interview process.

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RISK AND DISCOMFORT INVOLVED

There is no foreseeable physical discomfort or risk involved. If there are questions that are too sensitive for you to answer, you do not need to answer them. Below are the participants rights.

Your rights as a research participant

- Participating in this study is **completely voluntary** and **anonymous**.
- Information gathered during the research will be used solely for the purpose of this study and all efforts will be made to ensure the **confidentiality of participants' personal information is kept**.
- Please note that while your name will be recorded with the data, it will not be used in the report. All identifiable data will be **stored securely on a computer with password-restricted access** and only the researcher (and supervisor if applicable).
- The participant also has the **right of access to their data at any time**. All identifiable information will be **destroyed at the end of the study**.
- If you decide not to participate there will not be any negative consequences.
- Please be aware that if you decide to participate, you may **withdraw from the study at any time** and your data will be returned to you or destroyed. You may also decide not to answer any specific question.
- One has the opportunity to ask questions about the proposed study before signing the consent form.

Consent Statement

- I have read (or someone has read to me) the information in this consent form.
- I understand the purpose and procedures and the possible risks and benefits of the study.
- I was given sufficient time to think about it.

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- I had the opportunity to ask questions and have received satisfactory answers.
- I understand that I am free to withdraw from this study at any time for any reason and the decision to stop taking part will not affect my future relationships.
- I give permission to the use and disclosure of my de-identified information collected for use in this case study, as described in this form.
- I understand that by signing this document I do not waive any of my legal rights.
- I will be given a signed copy of this consent form.

____

Name of participant (please print)

________________________________ ________________________

Participant's signature Date

____

Name of researcher (please print)

________________________________ ________________________

Researcher's signature Date

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Witness:

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Annexure B

Interview Guide

(eg.Councillors, Mayors, Social workers, community leader, patients, nurses).

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Section A

Socio-Demographic Profile

1. Name:
2. Age:
3. Sex:
4. Occupation:
5. Languages Spoken:
6. Ethnic Group:
7. Where were you born?
8. How long have you been in this community?

Section B

Key Persons'- Primary Health Care Experience

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9. What does Primary Health Care mean to you?

10. Do people in the community know the concept of Primary Health Care?

11. What do you think is the Standard for a good Primary health care?

12. What could be done to encourage people to be more involved in community participation?

13. Are there programs at your clinic that educate people about Primary Health care and its significance?

    b) if so, how often are these programs implemented and who mostly attends them?

14. What is your view on the state of Primary Health Care at your clinic?

15. Does the clinic provide sufficient Primary Health Care for the community? If not, give reasons.

16. How is the relationship between nurses and doctors at the clinic?

Section C

Primary Health Care engagement

17. Are there any communication problems amongst stakeholders, i.e language barrier?

18. Are doctors or nurses involved in community activities?

19. What could be done to assist the nurses/doctors to involve the community more in community based programmes?

20. What could be done to improve nurse/doctor- Community relations?

21. To what extent has the economic conditions of the country affected primary Health Care?

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Section D

Primary health Care and Participation

22. How involved are you in the decision and implementation stages of PHC in your community?

23. Do you think if nurses and doctors participated more in the governance of Primary Health Care, conditions would be different?

24. Do you think the local government is operating at their full potential to improve primary health care in Dangamvura?

25. What strategies can be used to enhance stakeholder participation by the local government or council?

26. Do you think the community is participating enough on improving Primary Health care? Give reasons for your answer

27. What is your view on Government involvement in Primary Health Care and what measures have they implemented to improve the conditions

28. As a stakeholder what challenges do you face in your role towards improving PHC?

Section E

Integral Approach to PHC

35. Is there a platform available for the community, the medical practitioners and the community leaders to talk about Primary Health care?

36. Indicate your suggestions for the promotion of PHC in clinical training and clinical practice

37. How can partnerships between stakeholders assist on improving PHC?

38. What opportunities does PHC delivery offer in Dangamvura?

39.Are there any further comments regarding PHC strategic planning, organization, leadership, training and development and control that you would like to provide?

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Annexure C

Questionnaire

(Please tick on the appropriate response)

Age: 25 or less ___ 26 - 39 ___ 40 - 54 ___ 55 - 64 ___ 65 or over__

Sex: Male ___ Female___

Ethnic group: Black ___ White __ Other _____________

Marital Status: Married ___ Single___ Divorced___ Other ____________

Education: Less than high school ___ O'level/A'level __ Diploma ___ College/University degree or higher ___ Other_______________

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How do you pay for your health care? Pay cash (no insurance) ___ Health insurance (e.g.,) ___

Primary Health Care in the Community

How would rate our community as a "Healthy Community?"

Very unhealthy ___ Unhealthy ___ Average ___ Healthy___ Very healthy

(CODE FOR THE FOLLOWING QUESTIONS * 1 = a lot, 2 = regular, 3 = a little, 4 = not at all).

17. Are members of this community involved in identifying community health problems?

1 2 3 4

Are members of this community involved in identifying solutions to health care problems?

1 2 3 4

Are members of this community involved in implementing solutions to health care problems?

1 2 3 4

Are members of this community involved in evaluating health programmes?

1 2 3 4

Are you satisfied with the extent to which nurses / doctors interact with the community? Yes/No.

Do you think the nurses/doctors have good relations with the community at large? Yes / No

What does Primary Health Care mean to you?

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Do people in the community know the concept of Primary Health Care?

Do you think the community is participating enough on improving Primary Health Care? Give reasons for your answer.

Do you participate or attend Health care programs at the clinic?

How convenient is the clinics' location for you?

- Convenient
- Neutral
- Inconvenient

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Somewhat Inconvenient

How easy was it to get a follow-up appointment?

- Very Difficult
- Difficult
- Neutral
- Easy
- Very Easy

	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfie
Professionalism of staff at the clinic	○	○	○	○	○
Hygiene at the clinic	○	○	○	○	○
Care provided by medical personnel	◉	○	○	○	○
Time that a doctor spent with you	◉	○	○	○	○
Doctor and nurse relation	○	○	○	○	○
Patient Participation to health programs	○	○	○	○	○

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Annexure D

UNIVERSITY OF PRETORIA

DECLARATION OF ORIGINALITY

This document must be signed and submitted with every essay, report, project, assignment, dissertation and/or thesis.

Full names of student: MICHELLE RUTENDO TSONGA

Student number: 13084063

Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.
2. I declare that this dissertation (eg essay, report, project, assignment, dissertation, thesis, etc) is my own original work. Where other people's work has been used (either from a printed source, Internet or any other source), this has been properly acknowledged and referenced in accordance with departmental requirements.
3. I have not used work previously produced by another student or any other person to hand in as my own.
4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

SIGNATURE OF STUDENT: ....

SIGNATURE OF SUPERVISOR: ....

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Annexure E

UNIVERSITY OF PRETORIA

PLAGIARISM POLICY AGREEMENT

The University of Pretoria places great emphasis upon integrity and ethical conduct in the preparation of all written work submitted for academic evaluation.

While academic staff teaches you about referencing techniques and how to avoid plagiarism, you too have a responsibility in this regard. If you are at any stage uncertain as to what is required, you should speak to your lecturer before any written work is submitted.

You are guilty of plagiarism if you copy something from another author's work (eg a book, an article or a website) without acknowledging the source and pass it off as your own. In effect you are stealing something that belongs to someone else. This is not only the case when you copy work word-for-word (verbatim), but also when you submit someone else's work in a slightly altered form (paraphrase) or use a line of argument without acknowledging it. You are not allowed to use work previously produced by another student. You are also not allowed to let anybody copy your work with the intention of passing it off as his/her work.

Students who commit plagiarism will not be given any credit for plagiarised work. The matter may also be referred to the Disciplinary Committee (Students) for a ruling. Plagiarism is regarded as a serious contravention of the University's rules and can lead to expulsion from the University.

The declaration which follows must accompany all written work submitted while you are a student of the University of Pretoria. No written work will be accepted unless the declaration has been completed and attached.

Full names of candidate: MICHELLE RUTENDO TSONGA

Student number: 13084063

Date: 04-10-2019

Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.

SIGNATURE OF CANDIDATE:

SIGNATURE OF SUPERVISOR:

This document must be signed and submitted to the Head: Student Administration within two months of registering for the research component of the programme.

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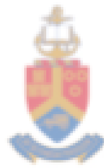
Annexure F



21 February 2020

Dear Miss MR Tsonga

Project Title:	What is the impact of promoting stakeholder participation to improve Primary Health Care: A case study of Dangamvura Ward 7 & 15, Mutare, Zimbabwe.
Researcher:	Miss MR Tsonga
Supervisor:	Dr S Moon
Department:	Anthropology and Archaeology
Reference number:	13084063 (HUM018/0919)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 21 February 2020. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely,

Prof Innocent Pikirayi
Deputy Dean: Postgraduate Studies and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof I Pikirayi (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr A-M de Beer; Dr A dos Santos; Ms KT Govinder Andrew; Dr P Gutura; Dr E Johnson; Prof D Maree; Mr A Mohamed; Dr I Noomé; Dr C Puttergill; Prof D Reyburn; Prof M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

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Annexure G

ADDRESS ALL CORRESPONDENCE TO THE
OFFICE OF THE DIRECTOR OF HEALTH SERVICES

No. 1 Queensway, Civic Centre
P.O. Box 910 Mutare, Zimbabwe
PHONE: +263 20 64412
EMAIL: mutarehealthdep@gmail.com

CITY OF MUTARE

IF CALLING OR TELEPHONING PLEASE REFER THE MATTER TO:
Dr A Mutara Ext. 203

Your Ref: ……….
Our Ref: AAM/can/research

Michelle Tsonga

2 October 2019

Dear Madam,

RE: **REQUEST TO DO A RESEARCH STUDY**

The above matter refers:-

I have no objection to your carrying out the above-mentioned research on the following conditions:

1) The study be purely for education purposes and the results will therefore not be published for public use without the permission of council.
2) **You will be required to do a presentation on the findings of your study to our department prior to presentation anywhere else.**

Yours faithfully,

DR A.A. MUTARA
DIRECTOR OF HEALTH SERVICES

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