A QUALITATIVE STUDY OF THE VIEWS OF KEY STAKEHOLDERS IN ZIMBABWE ON FAMILY MEDICINE

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DECLARATION

This study was approved by the Health Research Ethics Committee (HREC) at Stellenbosch University, reference number **S13/04/057** and the Medical Research Council of Zimbabwe reference number **MRCZ/B/597** and was conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

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ABSTRACT

Background

Zimbabwe has joined a number of countries that have recognized that family medicine offers an efficient way to meet the growing health needs of their countries. Like many other countries in sub-Saharan Africa, the country has a wide array of pressing health demands that its health delivery system has limited capacity to significantly counter. This has seen key stakeholders in the educational and health systems collaborating to introduce family medicine in Zimbabwe

Aim

To explore the views of key stakeholders on the introduction of family medicine in Zimbabwe.

Method

Twelve in-depth interviews were conducted with purposively selected key stakeholders in Zimbabwe. Data were recorded, transcribed and analysed using the framework method.

Results

Introduction of family medicine training in Zimbabwe was welcomed and it was perceived that this would result in improved equity, quality and comprehensiveness of primary care. Some of the threats were a deteriorating economic environment, poor remuneration and turf wars within the private sector. The concerns were a lack of a shared vision for primary healthcare by the stakeholders, lack of recognition of family medicine in the private sector and that family medicine was unknown.

Conclusion

Stakeholders anticipated significant benefits to Zimbabwe from the introduction of family medicine, but also recognised the existence of major barriers and threats to successful implementation.

INTRODUCTION

The World Health Report for 2008, *Primary Health Care: Now More Than Ever,* argues for more people-centred service delivery that focuses on health needs in a more holistic way and within an enduring personal relationship.[1] Care should be comprehensive, continuous and person-centred with responsibility of the primary care team for the health of the community served and not just the patient in front of them.[1,2] Family Medicine (FM) has a long tradition of promoting these principles and training doctors in this more person-centred and community-orientated approach. Members of the primary health care (PHC) team should work together to provide health care that is holistic, high quality, accessible, equitable, appropriate, comprehensive and cost-effective. [2, 3, 4, 5, 6] The effectiveness and efficiency of this team should improve with training and retaining adequate numbers of health workers, with an appropriate skills mix.[3] The team should include primary care nurses (PCNs), midwives, allied health professionals and FPs who are able to work in a multi-disciplinary context, in cooperation with non-professional community health workers (CHWs) in order to respond effectively to people's health needs.[3]

The 2nd African Regional WONCA (World Organisation of Family Doctors) Conference, held in Rustenburg, South Africa in October 2009 published a consensus statement on Family Medicine[4] that affirmed that FM within the African context has the potential to enhance equity, quality and comprehensiveness in PHC systems, while at the same time promoting efficient use of scarce resources. [4]

PHC is doctor-led in high income countries, while in public sector health systems in middle and low income countries; PHC is delivered by nurses and non-physician clinicians. Where resources allow, there may be supervision by district medical or nursing officers.[4, 9 - 12] In Sub-Saharan Africa, FPs work at district hospitals and may supervise the PHC team. [4]

African FPs are based at a district hospital providing secondary care, while the North American FPs work as first contact providers of primary care. Many scholars have raised questions about how closely African FM should follow the model developed in North America in terms of training, [9] and a report of a new FM training programme in Kenya described it as having "few similarities to North American FM education".[4, 11, 13]

Unlike Europe and North America, Africa must develop models that use the scarce skills of the FPs appropriately. Europe and North America can afford a system driven by doctors trained as generalists (as first contact) and African cannot because of resource limitations.[3] Nevertheless, Europe and North America are moving towards a more multidisciplinary approach with more nurses added to the team, while Africa is coming from the other end of the spectrum, trying to add more doctors to the team.[6] Therefore, the needs of African health and education systems

are very different from those that Europe and North America faced, only a generation ago, when they developed the discipline. [3, 4, 5, 6, 7, 8]

The last decade has seen a number of educational programs in FM begin throughout the African region as many countries have recognized that family medicine offers an efficient way to meet the growing health demands of their countries. [8, 14,15 16, 17, 18] Many countries in sub-Saharan Africa have similar health situations characterised by a wide array of health demands and a health system with a limited capacity. [17] There are varying views of stakeholders on what FM has to offer African PHC systems and hence different stages of development of FM in African health systems [7, 8, 14,15 16, 17, 18]

In an attempt to advocate and lobby for the introduction of FM, the College of Primary Care Physicians of Zimbabwe (CPCPZ) held a stakeholder's workshop in 2012 that conceptualised what FM might mean in the Zimbabwean context and aimed to introduce training by 2014. It was noted that FM was emerging and developing rapidly in the region, but it was emphasised that the international and regional examples were supposed to be used to develop a contextually suitable programme for Zimbabwe. However, integrating these experiences and the input of the local stakeholders into an appropriate model for Zimbabwe has remained a challenge. Amongst the most difficult issues to handle has been the grandfathering of doctors with previous qualifications or years of experience into a new discipline of FM. Apart from the workshop in 2012 there have been no other formal evaluations of the views of key stakeholders on FM in Zimbabwe.

AIM AND OBJECTIVES

The aim of the study was to explore the views of key academic, government and health profession leaders in Zimbabwe on the potential contribution of FM to healthcare and the need for training. Specific objectives included:

a) To explore perceived benefits of and concerns with Family Medicine
b) To explore views on the current and potential role of family physicians in the District Health Services
c) To explore views on opportunities and threats to implementation of training in Family Medicine
d) To explore views on the appropriate training of family physicians

METHODS

Study design

This was a phenomenological qualitative study that used in-depth interviews to explore the views of key stakeholders in Zimbabwe.

Setting

The Ministry of Health's (MoH) mission is to provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans, while maximizing the use of available resources, in line with the Primary Health Care (PHC) approach.[19] Post-independence, the Government of Zimbabwe (GoZ) invested heavily in health, especially PHC and the health of mothers and children. As a result, Zimbabwe recorded good progress in family planning, maternal and child health in the period 1980-1995. Thereafter, economic challenges, loss of skills and the HIV pandemic affected the health service delivery system and progress could not be maintained. Women and children, being more vulnerable, have been the most affected by the deterioration of some aspects of the health system.[20]

At the time of the study, CPCPZ was working closely with Stellenbosch University in South Africa and was partnered with the University of Zimbabwe's College of Health Sciences (UZCHS), and with the full support of the GoZ, to introduce FM training in Zimbabwe. This partnership saw a cohort of FPs being trained at Stellenbosch University and in 2015 three FPs graduated. The Medical and Dental Practitioners Council of Zimbabwe (MDPCZ) opened a new register for FM and the three were successfully registered marking the entry of FM in Zimbabwe.

The following organisations were regarded as key stakeholders by CPCPZ (the advocating organisation) in the provision of PHC in Zimbabwe: University of Zimbabwe College of Health Sciences (UZCHS), Medical and Dental Practitioners Council of Zimbabwe (MDPCZ), Ministry of Health and Child Care (MOHCC), Central Hospitals, Health Services Board (HSB), District Health Services, CPCPZ and Zimbabwe Medical Association (ZiMA).

The researcher undertook this study as part of the Masters of Medicine in Family Medicine at Stellenbosch University and was therefore a final year student of FM at the time of the study. He is amongst the pioneers to undertake studies in Family Medicine at Stellenbosch University. At the time of the study, he was part of the lobbying and advocacy group for FM training in Zimbabwe.

Sampling and selection

Criterion based purposeful sampling was used to identify interviewees. This entailed purposively selecting individuals who were actively engaged in the consultative processes for the introduction of FM in Zimbabwe as they were likely to be 'information-rich' and able to engage with the aim and objectives of the study. The researcher used the CPCPZ's list of stakeholders, mentioned in the setting above, and only those who had been in their post for the last 5 years were eligible for selection. Those who were engaged in postgraduate training for FM as well as those with FM qualifications were excluded.

After the first eight interviews, a preliminary analysis suggested there was need to perform additional interviews to explore emerging themes in more depth or to clarify issues raised. Snowball sampling was used to identify four additional interviewees that were likely to shed more light on the emerging themes or explain certain concepts in more detail.

Data collection

Open ended exploratory questions were used with reflective listening, summaries and clarification where needed. The interview guide (see Appendix 1) reflected the objectives of the study and ensured that all relevant topics were explored. The first three tapes were reviewed by the researcher and supervisor to ensure that the guide was appropriately constructed and that the researcher possessed necessary interviewing skills. The opening question was "May you please tell me what you know about FM, its benefits and any possible concerns". This was followed by other open ended questions (and appropriate prompts) that looked at the possible roles of the FP in the PHC and DHS as well as relationships with vertical specialists, views on expected skills and competences of the FP, human resource requirements and training sites. The future of untrained GPs was also explored. Finally respondents were asked to comment on the opportunities and threats to the introduction of FM training given Zimbabwean context.

These interviews were conducted from June 2015 to April 2016 when it was decided that there was sufficient data for analysis. Nine face to face in-depth interviews were performed by the researcher in the interviewee's offices and three were by cell phone and lasted between 30–60 minutes. Eleven interviews were performed in English and one was in Shona by the researcher.

Data analysis

All interviews were transcribed verbatim by a research assistant and these were then cross-checked against the audiotapes by the researcher. Any interview material in Shona (one interview) was translated into English. ATLAS-ti software was used to assist with the analysis of the data using the framework method. The framework method involved the following steps: familiarisation with the raw data; identifying an index of all the codes and categories to be used from the raw data; applying the index to all the raw data by annotating all the transcripts with the codes; charting all the data from the codes in one category into a single document; and interpreting themes from the charts in terms of the range and strength of opinions, as well as any associations or relationships between themes.

ETHICAL CONSIDERATIONS

The Health Research Ethics Committee of the University of Stellenbosch provided ethical approval under reference number S13/04/057 and the Medical Research Council of Zimbabwe reference number MRCZ/B/597. There was no monetary reward for participation. The data

remains confidential, and will be destroyed after 5 years. Respondents remain anonymous in all transcripts and analyses.

RESULTS

A total of 12 interviews were conducted as shown in Table 1. The researcher failed to obtain appointments with the Permanent Secretary to the MoH, the Director HSB and the Dean of the University of Zimbabwe's College of Health Sciences (UZCHS).

Table 1 – Profile of responders

Sector	Number of participants
Zimbabwe Medical Association (ZiMA) past president	1
CPCPZ national executive members	5
MDPCZ	2
Heads of tertiary hospitals	2
Senior District Medical Officer	1
Former HSB member	1

Benefits of Family Medicine to the health system

Effective functioning of PHC and DHS

Almost all respondents believed that a FP would improve the functioning of PHC and the DHS. In particular they conceptualised that the FP was better trained to deal with a wide range of community health conditions thereby reducing referrals to higher levels of care:

> *'….is a clear benefit in terms of the level of clinical management which is going to be offered in those institutions and hopefully going to cut down on the referrals which are going through to tertiary institutions* ' (Participant 11)

Comprehensive health care

The majority of respondents thought a FP would be better trained than the current healthcare providers to offer a wider range of health services to the community. These additional competencies were conceptualized as a mix of the vertical specialist's skills:

> ''*…clinical interventions must have some wide competencies in different specialties … wide and broad enough to take care of what is available in the common community*….' (Participant 7).

Improved clinical outcomes

It was conceptualized that greater accessibility to improved care across a wide range of health conditions would result in improved outcomes and reduction of complications due not only to better clinical care, but also an appreciation of one's limits:

> *'…with good family practice training, morbidity and mortality rates should not be so bad…you should be able to recognise problems before they happen and be able to know how best you can handle them, and … know what you can and cannot do and transfer on time.'*(Participant 7)

Roles and competencies of a family physician in the district health system

The competencies of a FP were conceptualized from the current roles of the GMO in a district hospital as well as the medical superintendent's management roles and clinical duties.

Care provider

All respondents expected the FP to be competently trained to deal with most health conditions in the district hospital and the associated PHC clinics, with emphasis on surgical and emergency skills:

> *'…the key competencies… in terms of maternal, neonatal and child health; …common conditions that we see. Are they able to look after major road traffic accidents and stabilize those patients before referral to secondary specialists?'*(Participant 10)

Specialist

The recognition of FPs as specialist by MDPCZ by opening of a specialist register in 2015 was conceptualised as putting them on a par with other specialists:

> *'There is no register which says you are a specialist but you know you are at sub-specialist or super specialist level. All specialists are at an equal platform as far as council is concerned.'* (Participant 11)

Capacity builder

Many of the respondents appreciated that as an expert generalist, a FP was a clinician with the necessary knowledge, skills and attitude to serve as a role model and a resource person to the healthcare team, including junior medical staff:

> *'You don't learn medicine from a book. You learn theory but you cannot learn how to take the history, how to examine a patient, how to have clinical skills if you don't see somebody else doing it.'* (Participant 9)

Supervisor

The respondents thought that the FP will take responsibility for supervising junior medical staff:

> *"…. making sure the GMOs and other junior medical staff have the right training, identify training they need...adequate CME/CPD activities,…the correct ....responsibility....basically working efficiently."*(Participant 11*)*

Monitoring resources for efficient use

Two senior respondents with a lot of experience as GMOs conceptualised that the FP should lead the district hospital team in saving scarce resources:

> *'You instil into these young doctors the issue that resources are finite and they run out, so unless they use them properly so that you stretch their use and impact…'* (Participant 10)

Leader of corporate governance

The role of corporate governance was conceptualised from a FP taking on GMO duties:

> *'... ultimately the doctor is responsible for everything, .staff, ... costs,... income, expenditure, cost containment ensuring discipline and all those things so all those things he can do or he can delegate some of those things. ' (Participant 12)*

Health education to prevent diseases

While health education and prevention activities for infectious diseases, which involve participation of the communities, were mentioned by one respondent, none specifically mentioned COPC:

> *'...I believe that if they get involved with the communities and assist them with other health care personnel and educate the population in preventing diseases, that's part and parcel of a Family Physician role.'* (Participant 12)

Possible training sites

Half of the respondents were in favour of decentralised training with appropriate supervision to ensure the production of quality FPs.

> '…so work based training is now very much in flourish and we already have quite a significant number of specialists who are not actually being trained at the College of

Health Sciences they are trained at the various institutions and became specialists and they are being registered by Council*...' (Participant 11)*

Concerns with the introduction of family medicine

Initiative taken by the private and not the public sector

Two respondents from the regulatory authorities thought that the initiative should have come from the public sector instead of the private sector with MOH as the main driver instead of CPCPZ:

'... the way we understand it particularly where they are being trained in South Africa ...are primarily being trained and targeted to ...Public Health setting ....that is the primary aim obviously they can also function in the private practice but the initial understanding we have in South Africa is ... to strengthen Public health care ... first and foremost and then .... it can then be extended to private practice.... but ... our pioneer cadres have actually been drawn from private practice.' (Participant 11)

Family medicine is unknown

Most respondents thought that FM was unknown because it was not taught both at undergraduate and postgraduate levels and there were no family physicians working in the health system:

'If there is no Family Physician in front of me, there is no way I can imagine being one.' (Participant 1)

Lack of recognition in private sector

A few respondents thought that in the private sector it may be difficult to obtain recognition for a FP with postgraduate training and a tendency to pay them the same tariff as GPs:

'They might just see you as you haven't changed, not wanting to upgrade your tariff thinking you are still the same. *' (Participant 1)*

Opportunities for the introduction of family medicine

International trend

Despite these concerns, the majority of the respondents were in support of introducing FM in Zimbabwe, because it was an international trend with other countries moving towards generalists having postgraduate training:

'And from a regulatory point of view again we refer to other councils which no longer actually register general practitioners. They have moved away from there because they

> *believe that such cadre must also undergo postgraduate training. No one must be left at a level like a static level of undergraduate… in future we are going to move in that direction where we eliminate the register of general practitioners and everybody is a specialist in whatever field they wish to pursue.'* (Participant 11)

Unequivocal government support

A few respondents strongly felt that the programme had the full support of the GoZ:

> *'…we have vowed to give our utmost support that such specialist training takes off sooner rather than later in this country…'* (Participant 11)

Availability of mentors

Half of the respondents noted that the country had already taken positive strides towards the establishment of FM through the CPCPZ's Stellenbosch University FM graduates who were expected to take leading roles in forming the initial nucleus of teachers of FM with the involvement of College membership and infrastructure:

> *'... the College needs to look at people who have been through the programme and they are going to say these are the skills that we have learnt and we can teach... either in their practices, ... but very importantly, the College needs to get involved in education.'* (Participant 9)

Need for continued lobbying

Some of the respondents noted that there was need for continued lobbying and advocacy by supportive stakeholders in order to bring awareness of the possible value of FM to the health system:

> *'I think ... people need to understand what Family Medicine is all about, ... this battle has been going on for some time. ..., I don't expect people to be just in line just like that but we have to convince them, fight for that, even convince the parliamentary committee and it should not be easy but, we shall succeed ...' (Participant 6)*

Buy in by academic institutions

One respondent from a regulatory authority noted that any academic institution was capable of hosting the FM programme, including the possibility of having the programme run from universities outside the country, as long the training could be accredited:

> *'So there is no longer an issue or a barrier to training that you have got to have your umbilical cord at … or any other local university for that matter.'* (Participant 11)

Need to re-orientate the PHC and DHS

Half the respondents thought that the time had come for Zimbabwe to change how the PHC system was working by incorporating an expertly trained generalist (FP), with the hope of making it more responsive to changes in the health needs of the population:

> *'... this is a course designed to meet the new changes in our society, whether you are talking about medicine in general or the way we have to approach surgical cases as a GP.' (Participant 2)*

Threats to the introduction of family medicine

Poor remuneration in both private and public sector

Some of the respondents conceptualised that the impetus was on the GoZ to overhaul its remuneration system to help retain FPs in remote areas; or allow private practice by FPs it employs:

> *'...the impetus then should be for government to provide a salary that doctors can live off to encourage them to stay within the hospital sanctuary system.' (*Participant 9)

> *'Government might employ the doctor full time but allow him to do his own private thing at the district centre or at the growth point. That will be another way of doing it.'* (Participant 1)

Harsh economic environment

Most of the respondents wondered how the FPs were going to be retained in the country given the sustained 'brain drain' of critical staff due to the deteriorating economy:

> *'We have lots of doctors all over in Canada, Australia, Botswana, and Namibia and here we are short of doctors. I recall at one time as a house man in the 80's in Mpilo we had cardiac surgery being done at Mpilo ... they have since gone away..'* (Participant 7)

Turf wars in the private sector

Almost all respondents thought that enhanced competencies across vertical specialist disciplines, for example in surgical or obstetric skills, would help the public sector health services. However, in the private sector, the possibility of lower patient inflows to the vertical specialists with the coming of FPs was seen as a possible area of conflict. However, all respondents concurred that mutual respect and working in a complimentary way would bring harmony to the medical fraternity:

'The specialists think you will be intruding into their domain because since you have done some further training in orthopaedics, further training in paediatrics, further training in obstetrics…' (Participant 1)

'Our attitude and the way we are going to work will have to change. But they should know we are not competing but complementing them. When we interact we should give each other respect.' Participant 1)

Lack of resources for FM

A few respondents conceptualised that with the GoZ failing to sustain the existing infrastructure, due to financial limitations, FM was not going to be resourced:

'*... there are so many things that have been planned and they have not been fulfilled as yet because there are no facilities, resources to follow up*.' (Participant 4)

DISCUSSION

Key findings

The key findings were classified into four main categories as shown in Table 2 below and these are anticipated benefits, anticipated barriers, opportunities and threats to implementation.

Table 2: Summary of key findings

Anticipated benefits	**Anticipated barriers**

• Expert generalists with five identified roles
  ○ care provider,
  ○ specialist / consultant
  ○ capacity builder and mentor,
  ○ monitoring resources for efficient use
  ○ leader of corporate governance,
  ○ supervisor of students
  ○ health education to prevent diseases
• Effective functioning of PHC and DHS with reduced referrals
• Improved access to more comprehensive services at DHS level
	• Initiative coming from the private sector
	• Family medicine is unknown
	• Lack of recognition in the private sector

• Improved clinical outcomes	
Possible opportunities • International trend • GoZ support • Availability of a few mentors • Buy-in by academic institutions • Need to re-orientate the PHC and DHS	**Possible threats** • Poor remuneration in the public and private sector • Harsh economic environment • Turf wars • Lack of resources for FM

Discussion of key findings

The respondents welcomed the introduction of FM training in Zimbabwe because of the anticipated improvement in the functioning of PHC and DHS with reduced referrals to higher levels of care. FM was associated with improved access to more comprehensive services at DHS level in the public sector and PHC thereby improving clinical outcomes

However, the harsh economic environment was seen as limiting the financial resources needed for a new training programme and establishment of posts for FPs. Some stakeholders argued that the GoZ was failing to sustain existing infrastructure due to financial limitations and they were wondering how FM was going to be resourced. They were therefore seeing it as almost impossible to envisage the introduction of a new specialist training in the health system given the harshness of the economy. It should be pointed out that FPs are not just an accessory to the primary care team but an essential ingredient whose absence may result in poor functioning of PHC and DHS. The whole health system will not work well and produce good outcomes if PHC and DHS functions poorly.[1, 2, 3]

Hospital centric views in Africa seem to suggest that the political elite and hierarchy are happy if the central referral hospital functions well even if health care to the rest of the population is poor.[2, 3] Public sector FM is also based at district hospitals with possible supervision of PHC as an important part of it.[9] Therefore, the value of FPs may depend on the political commitment to effective universal coverage, which is one of the goals in the new Sustainable Development Goals.[23]

In the interest of developing a sustainable PHC and DHS, donors may be encouraged to channel a proportion of the resources meant for vertical programmes towards the Zimbabwean FM implementation with its promise of development of comprehensive PHC and DHS with FPs as part of these systems. This will help Zimbabwe by addressing the current pressing health needs in the areas of maternal and child health, malaria, TB, HIV/AIDS as well as appropriately dealing with the emerging and growing need for non-communicable diseases care.[8]

While most regional countries are having economic challenges, Zimbabwe was going through a much harsher economic phase. It can be argued that the severe economic challenges could be used as an opportunity to build a vibrant PHC system based on its promise of efficiency, cost effectiveness, person centeredness and community orientation.[3] More-so, some stakeholders saw it imperative to follow the international trend of embracing FM with its promise of revitalising the health delivery system.

It was seen as almost impossible for doctors struggling with basic survival needs to attempt self-funding for postgraduate training. There is therefore a need for some donor support in the formative stages and possibly some scholarships for prospective candidates.

On employing FPs in the public sector, the stakeholders noted that poor salaries in the public sector will force doctors to work in both public and private sectors. Therefore, it may be conceptualised that most rural hospitals would fail to attract FPs as they would rather work in urban areas where prospects of setting up private practices will be much brighter. On the other hand , in the private sector, the comprehensive care which translates into seeing the widest range of patient conditions could be seen as a threat by vertical specialists and GPs with no further training might also perceive that FPs would attract and retain more patients. Nevertheless respondents encouraged a spirit of cooperation and mutual respect in the interest of strengthening the health delivery system.

On possible training and the requirements of a recognisable FM programme, the stakeholders advocated for a decentralised training of FM, mainly in the districts where most generalists would be working. On the other hand formal training requires proper supervision from a FP, which implies the trainees may have to move to where the training programme is established and supported,[28] especially given the expected shortage of trainers in the initial stages. Training people part time in situ without proper supervision is possible, but definitely not ideal. It could be a transitional phase in order to increase the number of FPs. In South Africa such training was not recognized by other specialists and was seen as part-time.[7] Delivering small numbers of well-trained FPs who really make a difference in a specific pilot area and who lay the foundation for more FPs later is probably a better way to go than starting with larger numbers of poorly trained people who do not fulfill expectations.

Zimbabwe has a cohort of FPs trained at Stellenbosch University in South Africa. There is good evidence that health systems and populations would greatly benefit from the contributions of a cohort of physicians who are specifically trained for, and supported in the clinical, educational, and leadership roles that a highly functioning and responsive primary care sector demands.[26, 31]

While the majority of respondents suggested a decentralized programme for FM training, pragmatically, the training of FM residents may have to start at teaching hospitals where the

other post-graduation training programmes are already established. The long-term training plan may be for FM to move to more peripheral training sites in locations approximating their eventual practice setting.[17] Just like other regional countries' programmes, a duration of four years as other specialists will address issues of rigour, recognition and clear career paths.[3]

While a number of doctors have taken FM training in countries like Britain, Canada and Australia, the use of these FPs may be limited by the difference in training requirements for Africa where a focus on district hospital skills is also needed. FM programmes for Africa are different from those in the high resource settings.[9]

CPCPZ should have a vision, like the Brazilian Society of Family Medicine, and should impress on its membership and doctors with only basic training as well as medical students that if they discover that FM is their passion, they should find ways, through government and academic institutions, to become expertly trained FPs and to help spread the new model of FM through role modelling and advocacy throughout Zimbabwe. [34]

Like other regional countries, Zimbabwe will train its FPs for the DHS.[8, 24, 28] Regional countries that have successfully implemented FM are advocating for a limited corporate governance role by the FP (DMO roles) as it is associated with frequent meetings and duties that are likely to take the FPs away from his or her clinical duties and therefore possibly reducing the FP's impact.[28, 33, 35] The stakeholders however continued to see the FP as having a role in management and this may reflect a lack of differentiation between clinical and managerial roles in the DHS.

LIMITATIONS

The researcher (CS) was a FM registrar at the time of this study, and a FM advocate. Although he did his level best to remain neutral whilst conducting the interviews, this interest could have affected his perception of the views expressed by the respondents. CS has worked as a GP with no further training in FM for more than 15 years and has been a member of CPCPZ for more than 10 years. Most of the respondents are known to him and some have worked with him. This fact may have affected the way they expressed their views, despite assurances of confidentiality. Some of the eligible participants could not schedule interviews to participate in the study for undisclosed reasons. They could have provided alternative viewpoints, but their reasons for not scheduling interviews were not known.

RECOMMENDATIONS

The following recommendations can be made on the basis of this study:

- The GoZ should urgently address working conditions and develop incentives that will attract and retain health workers in PHC and DHS in Zimbabwe.
- Centralised training during the initial phases of the introduction of FM training may be preferable given the limited resources and teachers of FM.
- FM is new; little understood and therefore requires continued lobbying and advocacy by FPs themselves.

CONCLUSION

Stakeholders believed that family medicine would improve access to more comprehensive PHC services with improved quality of care and clinical outcomes as well as fewer referrals to higher levels of care. Respondents were concerned about poor recognition and remuneration of FPs, the need to work in both private and public sectors to secure a sufficient income, resistance from other specialists competing for business in the private sector, and a lack of a clear vision for PHC in Zimbabwe within which FPs could be located. PHC is also suffering from a lack of infrastructure and resources. The respondents identified key roles for the FP which were similar to other countries in the region, although emphasized a managerial role more than elsewhere. Stakeholders recognized that a revitalisation of policy on PHC and DHS provided an opportunity to conceptualise the role of the FP and that many countries in the region were now embracing postgraduate training in FM. The harsh economic climate in Zimbabwe makes it difficult to create new posts or introduce a new discipline. Training will need to located within a higher education institution and make use of the few local FPs as trainers. An initial model of small scale training to a high quality with evidence of early impact in one part of the health system may be more persuasive in securing ongoing support.

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APPENDIX 1

A QUALITATIVE STUDY OF THE VIEWS OF KEY LEADERS IN ZIMBABWE ON FAMILY MEDICINE

INTERVIEW GUIDE: Questions

The **interview guide** (with prompts below):

- **Can you tell us about Family Medicine?**
    a. Benefits?
    b. Concerns?
- **What are your thoughts on the role of Family Medicine in Zimbabwe?**
    a. Currently?
    b. Potentially?
    c. In the District Health Services / Primary Health Care?
- **What do you think are the issues in implementing the discipline of Family Medicine?**
    a. Opportunities?
    b. Threats?
- **What are critical human resource issues to establishing Family Medicine?**
    a. What are your views on appropriate training in Family Medicine?
    b. Tell me about Family Medicine and the relationship with other clinical disciplines?
- **Do you have anything else to add?**
    a. What other aspects of the health care system are critical to the establishment of Family Medicine?
    b. What do you feel about the questionnaire?