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Personality, Coping with Work Stress and Gender Differences on Reported Physical Health Symptoms and Life Satisfaction

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Abstract

Work stress has increasingly gained prominence as a global concern that resonates with mental health issues. At issue are the organisation-related stressors that need to be profiled to come up with a bespoke employee assistance programme. Employee assistance programmes include empowering employees to use coping strategies to realise better outcomes in the stress-mental health relationship. However, personality as currently studied using the five factor model recognises that individuals are different. On this basis, it is important to factor personality in stress management programmes. This study was carried out in Harare's financial services sector in 2021. It was found that there were statistically significant correlations between emotional stability, mental and physical health outcomes, namely depressive symptoms, general satisfaction with life and somatisation. It was also noted that both males and females had similar perceptions of work stressors with differences observed on job role clarity and job control. Women were also more likely to resort to emotion-focused coping. Regression analysis using a quadratic equation was run as the data were not normally distributed, and emotional stability was found to be predictive of somatisation ($p<.05$). The findings have implications for stress management, recruitment and selection. For many jobs in the financial services sector, it is important to consider emotional stability as this personality domain has implications for bespoke stress management programmes that could be designed to address stressors in the workplace. Organisations need to appreciate the diverse needs of individuals and come up with interventions that address both the sources of stress and the individual differences in stress responses. Fostering a supportive work environment, providing training and resources are crucial initiatives to managing stress in workplaces.

Keywords: Work stress, personality, somatisation, regression analysis, employee assistance programmes

Introduction

Work stress is a pervasive issue that affects employees across various industries and levels of responsibility. The impact of work stress extends beyond just the workplace as it influences personal physical and emotional well-being, as well as overall life satisfaction. Understanding work stress requires an exploration of various factors, including personality traits, gender

differences, and coping mechanisms. Work stress results from an imbalance between the demands placed on an individual and the resources at their disposal to cope with the stressors. This study sought to unpack the relationships between work stress, mental and physical health outcomes with the idea being to improve stress management in workplaces. It is important to realise that the development of targeted interventions to enhance employee well-being requires an understanding of the factors that contribute to job stress and gender disparities in coping techniques. At a local level, organisations must be able to determine factors that could result in stress in their employees. Understanding the stress drivers then becomes the first step in crafting a relevant employee assistance programme. Many stress management programmes have generally been impaired by the inability to recognise that the experience of stress is an individualised emotional experience. Consequently, any programme geared at addressing the issues needs to be alive to this fact. The search for relevant and easy-to-deploy stress management programmes is a never-ending quest as each organisation is facing the fluid Zimbabwean economic environment.

Literature review

Understanding personality: The five-factor model of personality

Personality factors have been observed to contribute to life satisfaction and reported physical health symptoms. An example is the fact that highly emotionally unstable persons tend to engage in negative outcomes as a result of viewing a situation as more serious than it would be in reality (Freidman et al., 2014). Previous studies have also reported women as struggling more to come to terms with negative outcomes when compared with their male counterparts. Consequently, emotional stability and gender variables, as suggested by Matud (2004), can partially explain these gender differences because women, in general, encounter less controllable and generally more negative life events when compared to their male counterparts. Related to this concept is the idea that men have been socialised to use more active and instrumental coping behaviours, while women have been socialised to employ more passive and emotion-focused behaviours (Matud, 2004, p. 1411). Based on the reviewed research, this study expected that higher tendencies to engage in emotion-focused coping would be associated with higher levels of reported physical health complaints and generally poorer life satisfaction.

A further personality factor that could be related to life satisfaction was extraversion. The sociality facet was of relevance, particularly concerning burnout among clinical psychologists.

Extraversion has been argued to be of importance in understanding individual worker engagement and well-being in public service occupations (Bakker, 2015). However, sociality could conversely also lead to more effort being exerted on the job and therefore resulting in workers facing a higher risk of exhaustion. Concerning gender, Yarnell et al. (2015) argued that women could often be socialised as a norm to prioritize other people's needs ahead of their own and that women tended to be more critical of themselves as well as to have lower levels of self-esteem and self-compassion (Yarnell et al., 2015). Furthermore, other studies found that women tended to be more engaged in their near social environment than men (Caprara, Steca, Zelli & Capanna, 2005; McDonough & Walters, 2001; Paro et al., 2014). For example, Caprara et al. (2005) concluded that women tend to show more empathy and provide more emotional support to others, whereas men are more likely to engage in immediate and concrete helping actions that resonate with problem-focused coping strategies (Diekman & Clark, 2015; Gonzalez-Morales, Peiró, Rodriguez, & Greenglass, 2006). In addition, Paro et al. (2014) found that female medical students reported more emphatic and personal distress and emotional exhaustion compared to male students. Other research studies show that women reported more network-related events, that is, stressors experienced by others in their social network (McDonough & Walters, 2001).

Another aspect of sociality relates to individuals' self-construction. In brief, interdependent self-constructs refer to the tendency to identify oneself with the values prevalent in one's group (Markus & Kitayama, 1991). On the other hand, an independent self-construct is the tendency to see one's identity as separate from others in the surrounding social environment (Nisbert & Masuda, 2003). Studies of self-construct in the U.S.A. have found that women tend to have a more interdependent self-construct whereas men have a more independent self-construct (Cross & Madson, 1997). For clinical psychologists, higher scores on the sociality measures (prosociality and relational-interdependent self-construal) might be associated with being more prone to identify aspects of client cases as incomplete and thus deserving more attention.

Conceptualising work stress

The detrimental physical and psychological reactions that arise when a worker's needs, resources, or capabilities are not met by the demands of their job are referred to as work stress (Cavanagh et al., 2000). Numerous factors, such as an overwhelming workload, a lack of control, inadequate support, role ambiguity, and competing demands, can cause this mismatch. Workplace stress has far-reaching effects that might include reduced productivity and job

satisfaction as well as major health problems like anxiety, depression, and cardiovascular disease.

Personality and its relationship with work stress

Personality characteristics have a significant impact on how people view and handle stress. The five-factor model (FFM), which is comprised of neuroticism, agreeableness, extraversion, conscientiousness, and openness, offers a thorough framework for comprehending these variations (Turiano et al., 2013).

Neuroticism: A personality domain

Individuals high in neuroticism are more prone to experiencing negative emotions in the form of anxiety, anger, and depression. They are more likely to perceive situations as stressful and were hypothesised to struggle to cope effectively with work stress.

Extraversion: A personality domain

Extraverts were generally more sociable, energetic, and optimistic. They tend to have a positive outlook and are better at seeking social support, which could buffer the effects of stress.

Conscientiousness: A personality domain

Those high in conscientiousness were on the whole more organised, dependable, and disciplined. They are likely to have effective coping strategies and a strong sense of control over their work environment, reducing the likelihood of stress.

Agreeableness: A personality domain

Individuals high in agreeableness tended to be cooperative, compassionate, and good-natured. They also maintain positive relationships at work, which can mitigate stress. However, they may also avoid conflict as a strategy to improve team dynamics and this invariably can lead to exacerbating stress levels in the long run.

Openness: A personality domain

Individuals high in openness tended to be creative, curious, and open to new experiences and cultures. Though they can also actively seek out difficult circumstances that can raise stress levels, they are often more adaptive and robust in the face of stress.

Gender differences in the work-related stress experiences

Gender potentially plays a crucial role in shaping the experience and management of work stress. Socialisation processes and societal expectations often lead to different stressors and coping mechanisms for men and women. This often holds in African societies where there are

generally well defined roles for males and females. Women are more likely to experience stress related to Work-social life balance, discrimination, and interpersonal relationships, particularly in workplaces. They often face the dual burden of work and family responsibilities, which can exacerbate experienced stress. Their male counterparts, on the other hand, may experience stress related to job security, performance expectations, and financial pressures.

Coping mechanisms

Coping mechanisms are strategies that individuals employ to manage the demands of stressful situations.

Coping strategies can be broadly categorised into problem-focused and emotion-focused coping (Aldwin, 2007). Men are more likely to use problem-focused coping strategies, such as tackling the issue directly or engaging in physical activities. This active coping strategy involves addressing the source of stress directly. Effective coping can mitigate the negative effects of stress and enhance well-being. Strategies include time management, seeking solutions, and altering the work environment. For example, an employee overwhelmed by a heavy workload might prioritise tasks or delegate responsibilities to reduce stress. These strategies can be effective in resolving stressors but may overlook the emotional impact of the stress experience.

Emotion-focused coping involves managing the emotional response to stress rather than the stressor itself. Women tend to employ emotion-focused coping strategies, such as seeking social support and expressing emotions (Amin et al., 2022). Other strategies include engaging in relaxation techniques, and cognitively reframing the situation in a positive light. For instance, an employee might talk to a friend or family member about their stress or practice mindfulness to reduce anxiety. These strategies can be effective in managing stress but may not address the underlying problems.

Interaction of personality, gender and coping

The interaction between personality, gender, and coping strategies is complex and multifaceted. Personality traits influence the selection and effectiveness of coping mechanisms, while gender can moderate these relationships. Individuals high in neuroticism are more likely to employ maladaptive coping strategies, such as avoidance or denial, which can exacerbate stress. Extraverts on the other hand are more likely to seek social support, which can be an effective buffer against stress. Individuals high in conscientious tend to use problem-focused

coping strategies, which can help manage stress more effectively. On the gender variable, women often utilise social support and emotional expression as coping strategies, which could provide immediate relief but may not address long-term stressors. Men are more inclined to use problem-solving strategies, which can be effective in resolving stressors, but may neglect emotional well-being. However, depending on the stressor, it was noted that generally problem-focused coping tended to be the most effective coping method in workplaces.

Different coping profiles might arise from the interaction of gender and personality traits (Kuo, 2012). For instance, a very conscientious female worker may manage her stress effectively by combining problem-focused techniques with reaching out for social support. On the other hand, a neurotic male worker may experience difficulties with maladaptive coping, which raises stress levels.

How organisations have been intervening in the work stress

Organisations have a crucial role to play in the management of work stress through various interventions. Effective interventions can enhance employee well-being and productivity. Herein lies the challenge as they have to be certain of where and how they respond to the identified stressors within their control. The work environment itself is critical in creating a supportive work environment that can mitigate the levels of perceived stress (Baker & Schaufeli, 2008). There are many strategies that include clear communication, fair work policies, and a positive organisational culture. For example, providing employees with the resources they require to perform their tasks can reduce stress related to workload and role ambiguity.

Training and development through availing programmes that could enhance employee coping skills has been also noted to be beneficial. Stress management workshops, time management courses, and resilience training have been recommended so as to equip employees with the tools they need to manage stress effectively.

Employee assistance programmes (EAPs) also provide confidential counselling and support services to employees dealing with stress at the workplace. These programmes could address a wide range of issues, from work-related stress to personal problems. These could also be essential and well-appreciated resources for employees who may be in need.

Work-social life balance was also critical to addressing the work stress issue. This is because promoting equilibrium through employing flexible work arrangements, such as telecommuting

and flexible hours, could aid employees in managing their stress much better. Encouraging employees to take breaks and vacations could be the panacea for burnout and even reduce their stress levels.

Methodology

The research design

A quantitative co-relational cross-sectional survey (N=209) was used to collect data on job demands, job control, job resources, job roles, and social support using the HSEMSIT (R, 0.84). The sample size of 209 was deemed sufficient for a regression model because a minimum of 30 responds is more than sufficient to test a model without recourse to bootstrapping. The coping strategy was the mediator. A Google Forms link was created and participants had to go through an ethics section where they agreed to complete the questionnaire and they were also advised that they could withdraw their participation at any moment. Online assessments are of great help as they guarantee anonymity. The closed-ended questionnaire was completed online as it enabled the researcher to collect data rapidly and it was also convenient for the participants. The data were collected from middle management grades and; therefore, all respondents had access to a computer and internet connectivity.

Instrumentation

Instruments with known psychometric properties were adapted for this study. Reported physical health symptoms were assessed using the Somatic symptoms scale (R, 0.80) whilst general life satisfaction was measured using the GSWL scale (R, 0.85). Somatisation and life satisfaction were the dependent variables.

Personality was assessed using the International Personality Items Pool (IPIP50). Life satisfaction was assessed using the general satisfaction with life scale. The Beck Depression Inventory was adapted to measure depressive symptoms. The Health and Safety Executive Management Standards Indicator Tool was used to profile job-related stressors.

Results

The researcher used the Statistical Package for Social Sciences (SPSS version 26) to analyse the collected data. Data were exported from an excel file generated from the online google form responses. Descriptive statistics were indicated within the non-parametric tests done to test the study hypotheses, that is, there would be no statistically significant differences across gender on coping and experienced mental and physical health outcomes. The simple statistics carried

out were to ensure that the analytical process did not violate the assumption of normality in the data which is required to carry out inferential statistics. It was crucial to run normality testing as it sets the tone for any subsequent analysis.

Testing for normality

Testing for normality in inferential statistics is important for several reasons. Many parametric statistical tests, such as t-tests, ANOVA, and linear regression, assume that the data is normally distributed. A violation of this assumption can lead to inaccurate results, such as incorrect p-values and confidence intervals. While the central limit theorem states that the distribution of the sample mean will approach a normal distribution as the sample size increases, this approximation may not hold well for small sample sizes, particularly cross-sectional psychological data collected using questionnaires (Shapiro & Wilk, 1965). Importantly, tests that assume normality often lose power when the data are not normally distributed, leading to a higher likelihood of Type II errors (which is failing to reject a false null hypothesis). When normality is not present, other researchers have considered transforming the data, such as using log-linear transformation or using non-parametric tests that do not assume normality, or employing bootstrapping methods to make more reliable inferences. In this study, even with transformation, the data was found to be skewed.

Table 1: Normality Testing Table

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
SOMATISATION	0.098	209	0.000	0.959	209	0.000
DEPRESSION	0.154	209	0.000	0.926	209	0.000
GSWL	0.079	209	0.003	0.984	209	0.016
a. Lilliefors Significance Correction						

Table 1 shows that the outcome variables were all skewed using both the Shapiro-Wilk and the Kolmogorov-Smirnov tests.

Following the realisation that the data were not normally distributed the Mann-Whitney U Test was performed on the dependent or outcome variables. The following Table 2 summarises the results of the non-parametric testing of dependent variables.

Table 2: Hypotheses Testing

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of SOMATISATION is the same across categories of Gender.	Independent-Samples Mann-Whitney U Test	0.019	Reject the null hypothesis.
2	The distribution of DEPRESSION is the same across categories of Gender.	Independent-Samples Mann-Whitney U Test	0.510	Retain the null hypothesis.
3	The distribution of General Satisfaction with Life is the same across categories of Gender.	Independent-Samples Mann-Whitney U Test	0.416	Retain the null hypothesis.
Asymptotic significances are displayed. The significance level is .050.				

Table 2 above shows the statistically significant differences in somatisation with females reporting statistically higher levels of perceived physical ailments. There were statistically significant differences in the dimensions of depression and general satisfaction with life.

Summary descriptive scores on somatisation

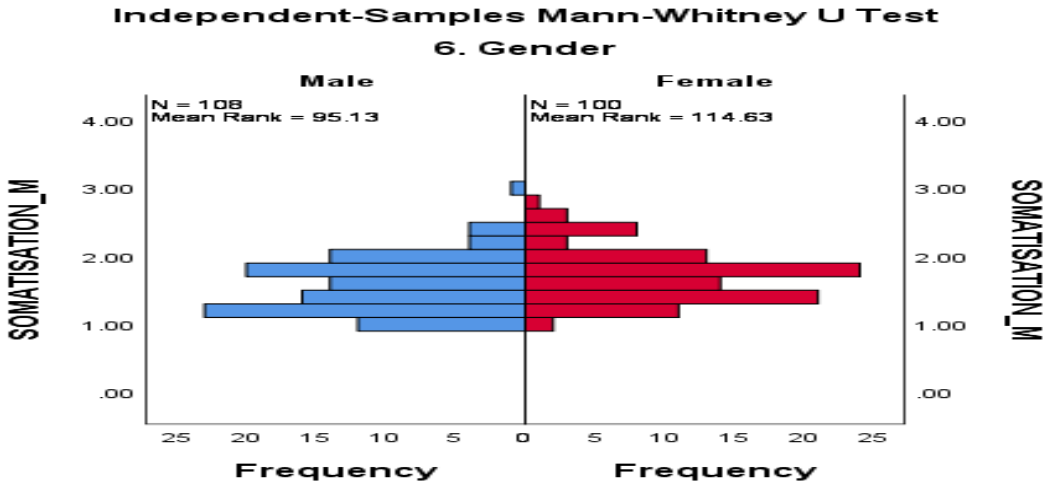

Figure 1: Somatisation and Gender

Figure 1 shows the mean scores with females having a higher mean score compared to their male counterparts.

Differences across gender on work stressors, coping, physical and mental health outcomes

Table 3: Independent Samples Test between Males and Females

Independent Samples Test between Males and Females										
		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Diff	Std. Error Dif	Lower	Upper
JOB DEMANDS	Equal variances assumed	.720	.397	-1.240	207	.216	-.14207	.11456	-.36792	.08379
JOB CONTROL	Equal variances assumed	2.034	.155	2.666	207	**.008**	.26922	.10096	.07017	.46827
JOB RESOURCES	Equal variances assumed	.074	.786	.976	207	.330	.13849	.14196	-.14138	.41836
JOB ROLE	Equal variances assumed	1.014	.315	2.208	207	**.028**	.15835	.07170	.01699	.29971
PROBLEM FOCUSED COPING	Equal variances assumed	.086	.769	.439	207	.661	.06041	.13776	-.21118	.33201
EMOTION FOCUSED COPING	Equal variances assumed	7.550	.007	2.488	207	**.014**	.25154	.10112	.05219	.45089

Results on coping strategies

Statistically significant differences were noted on emotion-focused coping and the summary diagram run from the Mann-Whitney U test shows the coping strategies based on gender.

Table 4: Coping Strategies and Gender

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of COPING_AVOIDANCE is the same across categories of Gender.	Independent-Samples Mann-Whitney U Test	0.494	Retain the null hypothesis.
2	The distribution of COPING_PROBEMFOCUSED is the same across categories of Gender.	Independent-Samples Mann-Whitney U Test	0.000	Reject the null hypothesis.
3	The distribution of COPING_EMOTIONFOCUSED is the same across categories of Gender.	Independent-Samples Mann-Whitney U Test	0.464	Retain the null hypothesis.
Asymptotic significances are displayed. The significance level is .050.				

On profiling of the organisation stressors, it was found that there were significant differences across genders in *Job Control* and *Job Role Clarity*.

There were also statistically significant differences in coping strategies with females noted to resort more to emotion-focused coping in comparison to their male counterparts. The summary below shows the average scores derived from the Mann-Whitney U test.

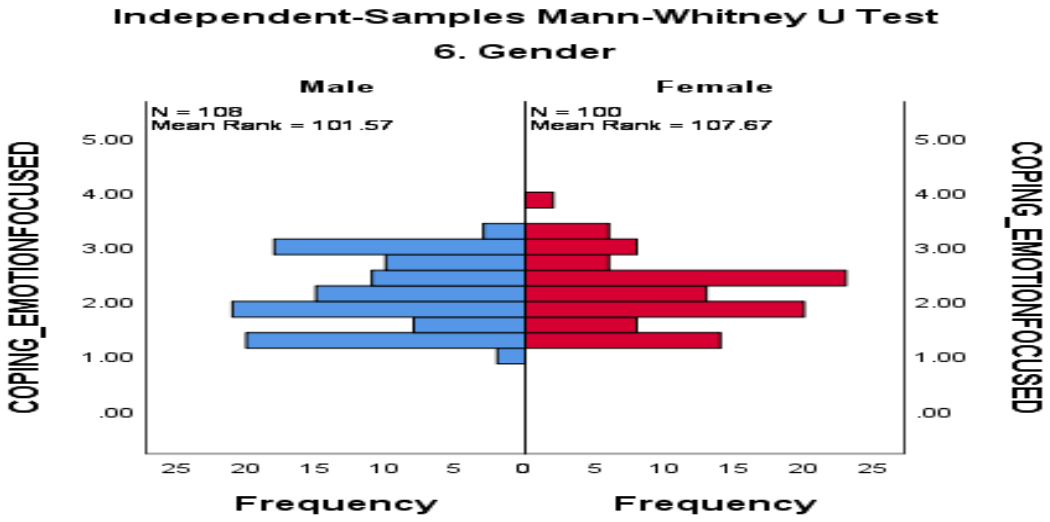

Figure 2: Coping and Gender

Graph showing means for emotion-focused coping strategies. The higher mean score of 108 for females against 100 for males shows that the former engaged in emotion-focused coping more than their male counterparts.

Personality and coping

Table 5: Correlations Table on Personality and Coping

	Correlations Matrices for Personality and Coping Strategies								
		1	2	3	4	5	6	7	8
1	COPING_AVOIDANCE	1							
2	COPING_PROBEM FOCUSED	0.120	1						
3	COPING_EMOTION FOCUSED	.410**	.157*	1					
4	EXTRAVERSION	0.125	.254**	-.189**	1				
5	AGREEABLENESS	0.003	.362**	-.151*	.323**	1			
6	CONSCIENTIOUSNESS	-0.059	.359**	-0.041	.318**	.468**	1		
7	EMOTIONAL STABILITY	-0.040	.360**	-.278**	.346**	.420**	.233**	1	
8	OPENNESS	-0.050	.318**	-0.007	.147*	.434**	.499**	.234**	1
	**. Correlation is significant at the 0.01 level (2-tailed).								
	*. Correlation is significant at the 0.05 level (2-tailed).								
	N=209								

Table 5 above shows the correlations between the five personality domains and the coping strategies employed. Noteworthy are the statistically significant inverse relationships between emotion focused coping and the domains of extraversion, agreeableness and emotional stability.

Emotional stability as a predictor of mental and physical health outcomes

A linear and quadratic equation was run with emotional stability as a predictor of somatisation, depression and general satisfaction with life. A quadratic regression analysis was run due to the non-normality of the data. Table 6 below illustrates the results.

Table 6: Regression Analysis Table

Model Description		
Model Name		MODEL_1
Dependent V	1	SOMATISATION
	2	DEPRESSION
	3	GSWL
Equation	1	Linear
	2	Quadratic
Independent Variable		EMOTIONALSTABILITY
Constant		Included
Tolerance for Entering Terms in Equations		0.0001

Table 6 above shows the regression analysis with emotional stability, a personality domain as a predictor of somatisation (reported physical health symptoms), depression and general satisfaction with life.

Model Summary and Parameter Estimates

Dependent Variable: SOMATISATION_M

	Model Summary					Parameter Estimates		
Equation	R Square	F	df1	df2	Sig.	Constant	b1	b2
Linear	.068	15.058	1	207	.000	2.100	-.149	
Quadratic	.068	7.563	2	206	.001	2.258	-.250	.015

The independent variable is EMOTIONALSTABILITY.

Figure 3: Model Summary and Parameter Estimates

The model above indicated emotional stability (as a predictor variable) to be statistically significant predictor of somatisation that accounted for 7% of the variance in the reported physical health symptoms.

Discussion

This study largely demonstrated that high job demands, coupled with low decision latitude, were generally related to low life satisfaction and higher reported physical health symptoms. These results go a long way in supporting the hypothesis that high levels of work stress could be linked to reported physical and mental health outcomes. Significant correlations $p<.01$ were found among the work stress variables and stepwise regression analysis demonstrated the effects of job demands and job resources on reported physical health $p<.001$. The five-factor model of personality was used to predict susceptibility to mental and physical health symptoms among the participants. It was found that individuals low in emotional stability tended to experience stressors more than those high in emotional stability. This finding resonates with a study by Muntean et al. (2022) who found a negative correlation between emotional stability and psychological well-being. This study also showed that women faced more stressors, particularly from role clarity and job roles within work spaces. This result resonates with the work-social life balance factor when comparing males and females. Men were generally more competitive and appear to cope better with work stress compared to their female counterparts. Coping strategies were almost equally employed particularly problem-focused coping because work environments by their nature require one to solve problems related to productivity. This resonates with the findings of Berridge and Cooper (2000) who found that women also tended to steer more towards social support as a coping mechanism when the going got tough. Women were more likely to seek advice and bank on the support of their colleagues. All the same, it was also noted that women tended to report higher levels of reported physical health symptoms compared to their male counterparts. To some extent, gender then becomes a factor in the stress-coping relationship. Coping was also found to be closely linked to personality variables with extraversion, agreeableness and conscientiousness being closely linked with active coping mechanisms. As Barling and Carson (2008) opined, the coping-personality link had implications for the type of employee assistance programme that the organisation may design. Increasingly, it is becoming apparent that these three dimensions of personality need to be factored into selection decisions and; furthermore, in stress management training. It is important to view employees as individuals with different stress tolerances and these differences cannot be divorced from the coping mechanism they are likely to employ. Work stress is indeed an everyday reality that both men and women face in the workplace and by profiling the stressors, organisations become better positioned to come up with bespoke programmes that could assist individuals afflicted by the work stress epidemic. Mental health

is an issue that can no longer be ignored as work stress has indeed shown clear relationships with both mental and physical health outcomes (ILO, 2016). Importantly, stress management programmes need to be guided by objectivity as there are many tools at the disposal of human capital practitioners to help them understand the nature of the stressors in their specific organisations.

The study was limited by its cross-sectional nature and future researchers are encouraged to use longitudinal and mixed methods designs in order to get a more holistic view of stressors within their organisations. A pre-test to determine current levels of stress and their sources, followed by a stress management programmes are crucial to comprehensively tackle stress within the workplaces. Post-tests would then determine the efficacy of the stress management programme as instituted. Longitudinal designs would also ensure that the stress management of employee assistance programme is improved as it could be rolled out in future endeavours. The reality is that workers in Zimbabwe and across the globe are increasingly facing volatile, uncertain, and complex environments. Workplace stress is dynamic and subject to vary based on a number of circumstances, including workload, role changes, organisational changes, and events in one's personal life. These variations are captured by longitudinal designs, which offer a more thorough knowledge of the evolution of occupational stress over time.

Conclusion

This study has confirmed that work stress is a reality as evident in the link that was established between high levels of work stress and reported physical and mental health indicators. Employers consequently have a moral and legal obligation to re-engineer jobs to come up with programmes that reduced mental and physical demands placed on workers. It can no longer be business as usual when stress has been confirmed to be related to organisational variables. When designing stress management programmes, it is important to consider the personality of individuals as there is no magic bullet to handling stress, particularly at work where individuals differ in their perceptions of stress and the resultant mental and physical health outcomes due to work-related stress.

Work stress is a complex phenomenon influenced by personality traits, gender differences, and coping mechanisms. Understanding these factors is essential for developing effective strategies to manage stress in the workplace. Organisations must recognise the diverse needs of their employees and implement interventions that address both the sources of stress and the individual differences in stress responses. By fostering a supportive work environment,

providing training and resources, and promoting work-social life balance, organisations can enhance employee well-being and productivity, creating a healthier and more resilient workforce. Human capital practitioners indeed can no longer afford to ignore the mental health of the worker. It is therefore important to understand stress within organisations through profiling it using valid and reliable tools.

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Addressing Gender Disparities in Healthcare Delivery: Strategies and Innovations for a Post-COVID-19 Era

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Abstract

Gender inequalities in healthcare have persisted for decades, with women often facing access barriers, poor treatment outcomes and inadequate care. The COVID-19 pandemic further exacerbated pre-existing inequalities. This qualitative study sought to explore the nature and impact of gender inequalities and identify strategies for addressing them in the post-pandemic period. A comprehensive search of multiple databases and sources was conducted, including PubMed, Google Scholar, and WHO publications. Search terms such as "gender disparities," "health care disparities," "women's access," and "COVID-19" were used in various combinations. A comprehensive literature review of databases from 2015 revealed that inequalities persist between different health services. Data were analysed using a thematic approach to identify key themes and patterns. Women reported facing sociocultural barriers, financial constraints, and a lack of autonomy in healthcare decision-making. They also suffered disproportionately from negative effects on their physical, mental, and economic well-being as a result of job losses, and increased family responsibilities brought on by the pandemic. Proposed strategies included gender-sensitive training for healthcare providers, involving women's groups in planning, increasing financial protection, and using technology to deliver integrated services. Concerted efforts are required to mainstream gender equality with community participation in all health systems. If left unchecked, pre-existing inequalities could persist and undermine public health goals.

Keywords: Gender inequalities, healthcare disparities, women's health, COVID-19, access barriers, strategies

Introduction

The problem of gender inequalities in health systems is a global problem that primarily affects women. According to the World Health Organisation (WHO) (2021), women's access to health services, information, resources and decision-making power is limited due to discrimination and prejudice caused by deep-rooted social and cultural norms. Addressing the underlying causes of these inequalities requires immediate attention as the COVID-19 pandemic has exposed and widened pre-existing gender disparities (Kauer et al., 20, 2021). The purpose of

this qualitative study conducted in Zimbabwe, was to examine the causes and effects of gender disparities in healthcare and to find solutions in the post-pandemic period. Similar to many other African countries, Zimbabwe has persistent gender inequalities in its healthcare system. These inequalities were exacerbated by the COVID-19 pandemic. Improving health outcomes and achieving national health coverage depend heavily on eliminating these disparities.

Background

Globally, there has been extensive evidence of gender disparities in quality and access to healthcare for decades. Through international agreements, national constitutions and supporting laws, progress towards achieving gender equality and universal health coverage has been made in many countries worldwide (UN Women, 2020). However, patriarchal social structures and sexism continue to permeate cultural beliefs, laws and practices that threaten the health, human rights and empowerment of women everywhere (EIGE, 2020). Women face barriers joining healthcare workforce where they occupy only 25% of professional positions (WHO, 2021). According to UN Women (2021), women's care experiences and outcomes are often worse than those of men because health services often do not adequately address their unique biological and social needs throughout their lives. Although there has been some progress, current published literature indicates that significant disparities still exist at sociocultural, economic and political levels (Langer et al., 2015). Many healthcare systems are constrained by deeply rooted social and gender norms. For example, a comprehensive analysis by WHO (2019) concluded that over 70% of 104 nations studied allocated smaller budgets to address women's health issues. The analysis also concluded that millions of women and girls worldwide still lack adequate financial protection through insurance coverage and formal employment.

Furthermore, gender differences in access to and quality of healthcare have been widely documented worldwide for many years. Women often face barriers to accessing preventive, curative and rehabilitation services for various health conditions. According to EIGE (2020), women face economic discrimination, barriers to education and barriers to joining the healthcare workforce globally hence exacerbating the gender pay gap. This disproportionately affects girls and women from lower socioeconomic backgrounds. Moreover, the advent of lockdowns and business closures during the COVID-19 pandemic resulted in millions of job losses, with women disproportionately affected as most are engaged in informal sectors such

as domestic work, agriculture and small to micro-enterprises without paid leave or sick pay protection (International Labour Organisation (ILO), 2019).

In the African context, gender inequality has its historical roots in patriarchal social norms that restricted women's autonomy and rights, marginalised their roles, and promoted traditional gender stereotypes of masculinity and femininity. These norms also justified discrimination as indicated by the National Biodiversity Strategy and Action Plan (NBSAP) (2020). Since then, most African nations have enacted new legislation and progressive constitutions that establish fundamental rights such as gender equality (Zimbabwe Ministry of Health, 2019). The ILO (2019) reports that systemic barriers, such as inadequate financing, weak implementation structures, patriarchal attitudes within policymaking spheres, and cultural norms that conflict with equality frameworks are still embedded in communities, impede the full realisation of these goals. As highlighted by Morgan et al. (2016), in most southern African countries, women's autonomy to make decisions about their sexual and reproductive health needs is weakened by cultural practices and beliefs. Adding on to that, Sen and Ostlin (2018) also submit that these practices and beliefs perpetuate the idea that "community health issues" are more important than "women's health issues" hence perpetuating inequalities. Furthermore, WHO (2021) highlighted that low status and restrictive patriarchal systems in many rural communities in Africa mean that women have little control over their healthcare and less access to health services. For example, in certain regions of West Africa, despite legal prohibitions, harmful practices such as female genital mutilation still continue, putting girls and women at risk of serious acute and chronic health problems (United Nations Population Fund (UNFPA), 2021). The WHO (2021) also noted that most African women are disproportionately affected by reproductive health issues because of high rates of maternal death, limited access to family planning and contraception as a result of poverty and flaws in the health system, and a lack of comprehensive sex education that would assist them to make informed decisions. As a result, cases of HIV/AIDS continue to be severely feminised with young African women in sub-Saharan Africa being three times more likely to get infected with the virus than men because of sexual violence, lack of control over condom use, and other sociocultural factors (UNAIDS, 2020).

Consequently, these existing vulnerabilities in health systems that disproportionately affect women have been exacerbated by the COVID-19 outbreak. Research concluded that women have been disproportionately affected as evidenced by an increase in gender-based violence

and reduced access to healthcare (WHO, 2018; UNFPA, 2021). This was also evidenced by the closing of most outpatient facilities and the sudden allocation of resources towards the pandemic, which also resulted in the disruptions to routine care service. Moreover, gender-disaggregated data from several countries also shows that, as a result of the pandemic, most women suffered job and income losses; and those greatly affected were women in the informal sector like domestic work, street vending, retail shops and tourism. This was worsened by lockdowns and social restrictions that significantly reduced the incomes of millions of people working in the informal sector, particularly in low-income areas (ILO, 2020). The restricted movement during lockdowns also resulted in limited access to sexual and reproductive health services hence negative impacts on prenatal, maternity and postnatal care (UN Women, 2020).

In Zimbabwe, the COVID-19 pandemic exposed the persistence of patriarchal norms that perpetuate gender disparities within the healthcare system. Reports by the Ministry of Health and Child Care in Zimbabwe (MOHCC) (2019) showed that patriarchal gender norms embedded in the country's laws, policies and communities have led to discrimination against women and health inequalities within the country. The NBSAP Zimbabwe (2020) also reported that a lack of public education, male dominance over resources and decision-making, negative attitudes and inadequate funding continue to create health implementation gaps despite progressive laws and policies on paper setting guidelines for gender equality and women's empowerment in Zimbabwe. This was exacerbated by harmful practices such as child marriages, which remain widespread and endangers girls' rights, health and education (Dziva et al., 2021). Furthermore, before COVID-19, access to services in Zimbabwe's health systems was already severely limited by a lack of both domestic and international funding, which made it difficult for the country to obtain enough qualified healthcare providers, equipment, and medications (Burke & Valdivia, 2021). Since 2000, the nation has also seen an intensifying economic crisis, with rising inflation rates significantly outpacing declining living standards, wages, and the calibre of public services (IMF, 2018). Because of this, more than 60% of the Zimbabwe population still depend on subsistence farming for food and income, making them more susceptible to changes in the weather and economic shocks as their level of poverty rises (FAO, 2021). Due to its disproportionate effects on women's safety, access to care, and economic security, the advent of the COVID-19 pandemic made the already existing gender disparities in Zimbabwe's health system worse. Just like in many other African countries, millions of women in Zimbabwe lost their jobs and income due to lockdowns and movement restrictions that restricted their earning opportunities, leading to a rise in household poverty

and financial instability (ZIMSTAT, 2021). Also, those who were working in the informal sector, for example, small scale enterprises, fruit and vegetable vending, domestic work, and the agriculture sector dominated by women, were greatly affected (ILO, 2020). To make matters even worse, the closing of schools during lockdowns resulted in a rise in stress levels as women and girls took on more caregiving duties, including cooking, cleaning, and childcare, regardless of their studies (Dziva et al., 2021).

Consequently, inequalities between genders in the healthcare system remained a problem in Zimbabwe. The full realisation of women's health and rights has been hampered by systemic gaps and socioeconomic barriers, despite legislative progress establishing principles of equality and non-discrimination. The COVID-19 pandemic exposed pre-existing disparities and had a disproportionately negative impact on women's well-being by exacerbating their vulnerabilities. Before the crisis, patriarchal norms and a lack of funding prevented Zimbabwe from implementing supportive policies effectively and women had limited access to healthcare. Many women gave birth without professional assistance, and rural communities faced significant distance barriers to services. Traditional practices undermined the empowerment of girls, while reproductive health programmes were concentrated in cities. Due to gender biases, the male-dominated system also neglected to satisfactorily consider the specific needs of women.

It is therefore still difficult to address the deeply ingrained gender disparities in healthcare and in society. Multi-sectoral strategies addressing root causes through policies, programmes, and systemic reforms led by meaningful participation of women and leadership are therefore required (WHO, 2020). Coordinated actions are now necessary to address the unequal health, social and economic impacts on women. Despite some progress made so far in many countries, as well as in Zimbabwe, the COVID-19 crisis has shown that patriarchal norms that perpetuate gender inequalities health sector remain resistant to change. Lessons must be learned from the difficulties encountered in responding to the COVID-19 pandemic to strengthen gender-responsive recovery and strengthen resilience to future health systems. Restoring healthier, more gender-sensitive systems requires more evidence-based policies and strategies than ever before (Kauer et al., 2021). If pre-pandemic inequalities are not addressed, they will continue to be damaging long after the COVID-20 era, particularly for disadvantaged groups within our societies (EIGE, 2020). The social factors that contribute to disparities in health systems between men and women need to be addressed through targeted interventions. It is now

essential to put a renewed emphasis on empowering marginalised groups to address systemic root causes to strengthen resilience against shocks in the future. Prioritising disadvantaged populations, and targeted remedies that consider intersectional identities and community-level factors are necessary to strengthen Zimbabwe's post-pandemic reconstruction.

Statement of the problem

Gender inequality in health systems is a global problem that primarily affects women. The World Health Organization (WHO) asserts that discrimination and prejudice caused by deeply rooted social and cultural norms limit women's access to health services, information, resources and decision-making power (WHO, 2021). The COVID-19 pandemic exposed and widened pre-existing gender gaps. Therefore, it is imperative that the underlying causes of these inequalities are addressed immediately (Kauer et al., 2021). Like many other African countries, Zimbabwe is experiencing negative impacts on women's physical, mental and financial well-being due to long-standing gender inequalities in the health system, and these were also exacerbated by the COVID-19 pandemic. Improving health outcomes and achieving national health coverage depend heavily on eliminating these disparities.

Research questions

i) What are the major gender disparities in healthcare service delivery and access before, during and after the COVID-19 pandemic in Zimbabwe?
ii) How have these disparities affected the physical, mental and financial well-being of women in Zimbabwe?
iii) What innovative and successful approaches can be used to address gender disparities in the post-COVID-19 health system in Zimbabwe?

Methodology

This study used a document analysis methodology that employed a qualitative research design. According to Creswell and Creswell (2018), a qualitative approach made sense given the goal of examining complex issues of gender inequality and identifying viable solutions through the analysis of written evidence. Relevant documents were found by using keyword combinations such as “gender disparity”, “health care Zimbabwe” and “women's access post-Covid-19” to search databases such as PubMed, Google Scholar, WHO Global Health Library and organisational repositories. Documents included in the collection of the pertinent data were those published between 2015 and 2022 that provided context for Zimbabwe and other African

countries. Fifteen documents were retrieved that met the criteria and from these documents data was collected. Purposive sampling was used to select documents that contained detailed information on the study objectives from authoritative sources such as Ministry of Health reports, WHO country assessments, NGO briefs, and peer-reviewed articles (Peters et al., 2020). Recent publications with gender-disaggregated qualitative and quantitative data on the impact of COVID-19 and the opinions of key stakeholders were also prioritised. The sample size was determined by data saturation (Guest et al., 2006).

The research used thematic analysis following the guidelines of Nowell et al. (2017) to uncover critical concepts through a thorough examination of the documents. A list of initial codes was created and then divided into potential themes covering different aspects. These themes were refined, defined and supported with evidence to achieve the study objectives. To ensure the reliability of the analysis, a peer review process was implemented in which a peer researcher double coded a sample of the data to compare consistency. An agreement rate of over 90% was achieved, meeting the recommended standard for demonstrating credibility in qualitative research (Creswell & Miller, 2000). The analysis was conducted using publicly available secondary data sources to protect the anonymity of individuals and maintain confidentiality. The research results would be shared to achieve broader benefits without compromising the privacy of the organisations mentioned in the documents. However, the researcher acknowledges limitations such as differences in depth and scope of data in this study.

Presentation of findings

These findings are based on information from verified documents. Several factors have surfaced that address the nature of gender differences in health systems before and during the COVID-19 pandemic. Disparities were found in various health categories such as maternal health, sexual reproductive health, non-communicable diseases and mental health. Findings also revealed that there was an increase in disruptions to health systems during the pandemic, which also had a major impact on the lives of marginalised groups. The pandemic had a major impact on people's sexual reproductive health, livelihoods and education, among others. This was exacerbated by the lockdowns and movement restrictions due to the pandemic.

These findings also informed the possible strategies to address these gender disparities in our healthcare system. Information from the documents reviewed indicates that some of the proposed strategies include, among others, integrating gender into all COVID-19 policies and programmes, implementing gender audits in health systems, implementing awareness and

engagement programmes, and developing financial mechanisms for disadvantaged groups and monitoring and evaluation of these activities, among others. These findings are presented thematically based on the objectives of this study.

(a) Gender disparities in healthcare delivery pre-COVID-19

Maternal health

Documents reviewed found that, although maternal mortality rates in Zimbabwe had declined since 2000, many women continued to have unequal access to quality antenatal, delivery and postnatal services (WHO, 2019). There was a severe shortage of female nurses, midwives and doctors, particularly in rural areas, leading to a higher likelihood of obstetric complications due to delays in care (MOHCC, 2017). Traditional beliefs also negatively impacted health-seeking for maternal needs, with some communities perpetuating practices such as wife inheritance that put widowed mothers at risk (Chadamoyo, 2018).

Sexual and reproductive health

Before the pandemic, reports showed that Zimbabwean women faced obstacles such as a lack of autonomy and financial hurdles that made it difficult for them to access family planning, screening and treatment for infections such as HIV/AIDS (Ministry of Health, Labour and Social Services, 2019). Gender differences in HIV prevalence resulted in women being at higher risk without adequate support services tailored to their vulnerability (UNAIDS, 2020). Adolescent girls had difficulty obtaining contraceptives and counselling due to conservative social norms that prevented open discussions about sexuality, especially for the yet to be married young women (UNFPA, 2018).

Non-communicable diseases

According to national health surveys, over the years women in Zimbabwe were more likely to be affected by non-communicable diseases such as heart disease, diabetes, high blood pressure (BP), asthma, depression and certain cancers (e.g., breast, lung and colon) (Kamvura et al., 2022). Unfortunately, risk assessment, early detection initiatives and treatment plans are not tailored to address gender differences in the development and progression of these diseases. Furthermore, health promotion efforts have predominantly focused on communicable diseases like influenza, malaria, TB, and HIV/AIDS, among others, and failed to educate the public about lifestyle factors that contribute to noncommunicable diseases, which are prevalent among middle-aged and older women (ZHDR, 2018).

Mental health

Most research studies done before the advent of COVID-19 revealed that mental disorders significantly contributed to poor health among women and girls in Zimbabwe. This was primarily attributed to factors such as gender-based violence, poverty, inadequate nutrition, and lack of sufficient support systems (MOHCC, 2015). Moreover, Maeresera (2022) also noted that primary care service providers offer insufficient psychosocial support and specialised psychiatric care, particularly in most rural communities. This was also worsened by traditional beliefs that contributed to the under-reporting and under-diagnosis of conditions such as depression and PTSD, resulting in treatment gaps for women and girls (Chibanda et al., 2016).

Out-of-pocket expenditures

In line with expenditure, the documents reviewed revealed that high costs of living continued to prevent many women from accessing necessary health care due to low income, lack of health insurance coverage and limited alternative financing mechanisms before the advent of COVID-19 (Zeng et al., 2018). This was worsened by how public institutions charged their consultation and treatment fees, which were being charged without taking into cognisant levels and sources of income of people in their communities (HSGZ, 2018). As a result, many pregnancies were treated at home and chronic diseases remained uncontrolled because most women could not afford expensive diagnostics or medications from private healthcare providers (ZHDR, 2017).

(b) Impact of COVID-19 on healthcare delivery during the pandemic period

Documents reviewed revealed that studies on the gender impact of the pandemic in Zimbabwe have shown that women faced greater risks of infection and suffered more severe health, social, and economic consequences due to existing vulnerabilities that were exacerbated by lockdown and movement restriction measures. The pandemic had a major healthcare disruption that impacted people's sexual reproductive health, livelihoods and education, among others.

Healthcare disruptions

Findings from documents reviewed revealed that hospitalisation records from most health institutions indicated a significant decrease in outpatient visits during the peak of lockdown and movement restriction measures, with public health facility utilisation dropping by over 40% (MOHCC, 2020). This decline was mainly due to reduced access to non-COVID-related services, particularly affecting women. Maternal health services experienced notable disruptions as attendance for antenatal care decreased due to concerns about potential exposure to the COVID-19. Furthermore, limited access to transportation as restrictions intensified also

prevented high-risk pregnant women in remote rural areas from visiting maternity hospitals and clinics, leading to a rise in unsupervised home-based deliveries, for example, the use of midwives (*mbuya utano*) where unsterilised gloves and razor blades were used. Moreover, findings also showed that treatment of chronic non-communicable diseases was also affected, with drug shortages, closures of chronic disease clinics and disruptions to health supply chains affecting continuity of care for conditions such as hypertension and diabetes, which predominantly affect women. This led to uncontrolled symptoms and poorer health outcomes. In addition, access to mental healthcare was further limited by social restrictions that separated patients from community-based counselling services, leading to a drastic increase in mental health disorders during the stressful period of the pandemic. Moreover, the telemedicine initiatives launched by the Ministry of Health faced some implementation challenges. Telemedicine implementation was hindered by limited internet penetration and technological literacy, especially among older women in rural areas (POTRAZ, 2019). This resulted in discouraging healthcare seeking for many non-emergency conditions. Furthermore, with schools closed for more than six months, full responsibility for childcare fell to women and girls since they were always domiciled at home. The pressure of the unprecedented quadrupling of care work resulted in high levels of stress, fatigue and anxiety among women (MHRR, 2021). Hence, their livelihoods were greatly affected since most of their usual time dedicated to income generation activities was now diverted to domestic duties.

Livelihoods and poverty

Findings revealed that the informal sector, where over 70% of Zimbabwean women earn their living, was hit hardest by the lockdowns and movement restrictions. Sectors that were heavily affected were the hairdressing, fruits and vegetable vending, cross-border trading and even some parts of the agriculture industry (ZIMSTAT, 2020). Findings also exposed that millions of people fell into extreme poverty as soon as they lost their daily wages because there were no social security programmes. As the country enforced movement restrictions, remittances from family members in bordering countries also fell significantly (IOM, 2021). Due to the lack of alternative income opportunities and social support networks, most women especially single ones experienced higher rates of hunger and homelessness. As a result, over 50% of people living in cities were unable to pay for essentials such as food, rent and medical care, pushing poverty to its highest level during this period.

Gender-based violence

Documents reviewed revealed that a widespread escalation of intimate partner violence was witnessed as many victims were spending more time alongside perpetrators due to lockdown and movement restriction measures (ZWRCN, 2021). These restrictions removed the usual support networks and coping mechanisms hence the increase in GBV, especially intimate partner violence. Moreover, fear of social stigmatisation was noted as one of the major factors that discouraged women from reporting, as perpetrators threatened to expose lockdown violations. As a result, incidents of physical and sexual violence increased in both frequency and brutality. According to a report by the Ministry of Women's Affairs (2021), over 60% of GBV cases reported involved serious injuries and the use of weapons against helpless partners and children. This was also worsened by the failure of traditional and religious leaders who had difficulties in resolving disputes as stress increased in communities that lacked resources to cope. The lockdowns further limited access to justice as court hours were also shortened and this encouraged perpetrators who took advantage of the absence of imminent legal retribution for their outrageous acts (ZHRC, 2021). With limited resources, combating COVID-19 took precedence over long-term gender-based violence prevention programmes, and the shadow pandemic of violence persisted.

Sexual and reproductive health

Reviewed documents also reported sexual and reproductive health concerns during the COVID-19 pandemic. Findings from these documents revealed that the provision of essential sexual and reproductive health services during the pandemic was hindered by the allocation of staff and resources to the COVID-19 response, resulting in the prioritisation of emergency procedures. This led to a decrease in access to routine family planning, prenatal care, and cancer screenings for women and girls. Furthermore, outreach programmes that used to deliver contraceptives to rural areas were discontinued, hence exacerbating the problem. It was also revealed that the closing of schools heavily impacted access to condoms and educational materials for adolescents, leading to a decrease in safe sex educational activities. Restriction of access to these services was also worsened by fear of contracting the virus at crowded facilities where these services were offered. Furthermore, limited transportation due to movement restrictions hindered HIV testing, infant feeding support programmes, and follow-ups for survivors of gender-based violence.

(c) Strategies and innovations for a post-COVID-19 era

The reviewed information suggested several innovative measures that can be taken to address various gender disparities that existed within the health systems which were also intensified by the advent of COVID-19. These strategies are explained below.

Integrating gender in COVID-19 policies and programmes

Most reviewed literature suggests that gender focal points be established within emergency response coordination structures to ensure that protocols ought to consider the different needs, barriers, and vulnerabilities faced by various groups (UN Women, 2021). Analysing fiscal relief packages and care guidelines through a gender lens could help address the disproportionate social and economic impacts faced by certain populations.

Gender audits of health systems

To address gaps in reproductive, primary care, mental health, and community health workforce programmes heavily used by women, reviewed documents highlighted assessments to track resource allocations and access disparities (ChiZwHA, 2021). Budget support from external donors should therefore prioritise revitalising dysfunctional women-centred programmes and services (WOZA, 2021).

Awareness-raising and engagement

Mass media and social education interventions that challenge toxic masculinity and promote positive masculinity have been noted as important in changing restrictive social norms that fuel inequalities (ZWRCN, 2021). Advising women's groups on planning broadened grassroots perspectives on obstacles and possible solutions (MWAGCD, 2021).

Respectful maternity care

The focus of most studied literature was on the development of the capacity of health workers to provide non-judgmental and trauma-informed treatment specifically tailored to the needs of marginalised women (Hughes et al., 2022). To provide access to lifelong health support, community midwifery models should be improved to reach remote communities (CHITA, 2021).

Financing mechanisms

Some of the reviewed documents have proposed social insurance programmes and universal health insurance to protect women from crippling out-of-pocket medical costs and promote continuity of care (ILO, 2021). To promote economic empowerment and reduce vulnerability

over time, some documents also proposed the introduction of conditional cash transfers, microcredit programmes and skills training measures (UNDP, 2021).

Multi-sectoral coordination

To address overarching challenges such as increasing gender-based violence, most of the reviewed documents suggested protection from threats and exacerbation of causes of poverty for non-health reasons, and a comprehensive strategy covering education, social welfare, finance and women's ministries. Literature also revealed that the involvement of religious and traditional leaders can contribute to the sustainability of community-led changes (HelpAge Zimbabwe, 2021).

Monitoring and evaluation

To ensure that programmes reduce gender inequalities, studied literature recommended the use of disaggregated qualitative and quantitative indicators to track impact and this can result in guiding iterative optimisations (WHO, 2020).

Discussions of findings

Based on the findings from the various reviewed documents pertinent to this study, it can be confirmed that gender disparities in health care and access were already widespread in Zimbabwe before the COVID-19 pandemic. Findings concluded that the underdiagnoses of non-communicable diseases affected women in various ways, for example, high out-of-pocket costs that discouraged health care use, barriers to sexual and reproductive care, unequal maternal health care, and inadequate attention to mental health issues. The national health surveys and reports from Zimbabwe examined for this study supported findings from previous studies in other African countries showing disparities in maternal health between rural and urban areas due to a lack of trained obstetricians and emergency obstetric care facilities, which disproportionately affected women (Kruk et al., 2018). Studies revealed that similar cultural beliefs limit women's health choices and undermine progress in other African countries such as Zimbabwe are consistent with findings about the continued influence of traditional norms and practices that undermine women's autonomy in sexual and reproductive decisions (Akachi & Kruk, 2017). Similarly, barriers in the unequal prioritisation of programmes for the life-course health needs of women compared to men across much of Africa have also been highlighted in the areas of cervical cancer screening, uptake of HIV/AIDS prevention services, universal access to modern medicine and identified contraceptive options (Simbayi et al.,

2017). Due to conservative socio-cultural barriers, results concluded that single adolescent girls could not be reached through youth-friendly approaches with stigma-free counselling and care

Furthermore, the findings highlighted gender differences in disease expression and threats thereby neglecting addressing the increasing non-communicable disease burden. This is consistent with the neglection of epidemic of non-communicable diseases that disproportionately affected African women but were not adequately addressed by financing, community education and health policy (WHO, 2011). Moreover, findings also mentioned Zimbabwe as one of the countries where women are deprived of essential community mental health support services. This can be supported by evidence of significant gaps in mental health treatment, where women's plight was excluded from mainstream care (Lund et al., 2011). Results also outlined various approaches to overcoming gender disparities exacerbated by the COVID-19 epidemic. It was noted that mainstreaming gender in all aspects of health planning, financing, service delivery and monitoring and evaluation by integrating expertise into relevant policymaking, budgeting processes and guidelines developed, is a strategy that has the potential to have a significant transformative impact (WHO, 2021). This approach is consistent with recommended practices in research that support the need for gender-responsive health systems that consider the needs, priorities and analysis of both genders to achieve equitable outcomes (Kuhlman et al., 2021).

It was also revealed in the results that comprehensive gender-sensitive reviews of resource flows and access patterns in the Zimbabwean health sector could support mainstreaming efforts by helping to identify specific vulnerabilities that would enable strategic sector investments that address underlying causes. Research confirms gender auditing techniques as crucial tools for tracking progress in addressing imbalances (EIGE, 2020). A proposed strategy, consistent with research highlighting the importance of gender-disaggregated indicators for impact tracking and iterative course corrections, is to strengthen regularly collected gender-disaggregated health data to support decision-making (UN Women, 2021). Other innovative tactics highlighted by findings as promising included capacity-building programmes for the trauma-informed and respectful maternity care that improve coverage and quality for marginalised women (Nikodem et al., 2021). Community midwifery models (use of *ana mbuya utano*) that increase grassroots reach have been particularly highlighted due to their focus on best practices in supporting women's access to comprehensive lifelong health care (WHO Regional Office for Africa, 2019).

Conclusion

This study provides insightful information about the nature and extent of gender disparities in health care delivery and access that already exist in Zimbabwe, as well as the unique impacts of the COVID-19 pandemic that are exacerbating inequities for women. Findings demonstrate the existence of structural barriers and socioeconomic factors that limit health outcomes for women in diverse service settings. Routine care has been disproportionately impacted by the epidemic and the impact on marginalised groups has not been adequately addressed. It also offers the opportunity to rebuild using gender-responsive, egalitarian strategies that increase community resilience. Therefore, a consistent effort is required to implement coordinated initiatives and legislation that support the achievement of universal health coverage based on equality between men and women. Pre-existing gender inequalities have the potential to exacerbate the long-term health impacts of the COVID-19 pandemic on women and communities unless they are addressed through targeted, rights-based solutions. As Zimbabwe continues to recover from COVID-19, the recommendations highlighted below offer an opportunity to urgently reverse inequities and build stronger systems.

Recommendations

Based on the key findings and the proposed strategies, several recommendations have emerged:

i) Gender knowledge must be considered at all stages of planning, policymaking, and budgeting cycles, as well as service delivery policies, protocols, training and infrastructure development in Zimbabwe's health facilities.

ii) To ensure that equal health rights are maintained for men and women, explicit goals and metrics are needed to monitor the reduction of disparities.

iii) To identify priority areas for investment in closing gaps, a thorough gender review of resource distribution patterns and access disparities should be conducted regularly.

iv) It is imperative to include women's groups and civil society leaders to actively participate in campaigns to promote community participation in reform initiatives. Particularly in remote rural areas where access to primary care is limited, expanding the scope of community-based midwifery models and establishing mobile clinics may be helpful.

v) Policymakers must work with partners to coordinate cross-sector initiatives in areas such as domestic violence prevention, employment development, education and poverty reduction.

For future research studies, I suggest that these ought to examine effective implementation models for proposed tactics such as incorporating gender education into career readiness curricula or developing conditional financial assistance plans that have been shown to improve equal access. The unique needs of marginalised groups should be identified through qualitative research on the intersectional vulnerabilities and systemic constraints faced by subcategories such as adolescent girls, minority groups, older women, and people with disabilities. Moreover, analysing excellent practices in different African contexts and comparing them could provide transferable knowledge across the continent.

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Assessing Quality of Online Supervision of Trainee Counsellors: The Case of Counsellor Training Institutions in Zimbabwe

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Abstract

Counselling is a health profession that calls for practical training. During the COVID-19 lockdowns, many students found it difficult to get field placements unless they were already in health service jobs, which gave them the chance to meet clients in their organisations. The study set out to establish how students were supervised in the field during the COVID-19 lockdowns and how these assessments were done in a restrictive environment. Interpretive qualitative research methods were employed to gather and collect data from the students and the university supervisors. Unstructured interviews, interview guides and telephone interviews were used. The findings revealed that students had to find their own way of getting assessed and some postponed their studies due to lack of placement in the appropriate organisations. In some instances, online supervision was the only option for those who were hard to reach. WhatsApp video conferencing became convenient for trainees attached to sites that had weak connectivity and those who lacked resources that would enable connection to platforms such as zoom and teams. For those who got placement at their workplaces, the training was not as vigorous as it should be. Findings also revealed that training institutions were not prepared for global emergencies such as the COVID-19 pandemic. It is recommended that training institutions should find innovative ways for student supervision to continue flawlessly in this 4th Industrial Revolution. There is also a need for institutions' strategic plans to include resources and programmes in times of serious national or global emergencies.

Keywords: Counselling, COVID-19 lockdowns, health profession

Background to the study

The counselling profession developed in the late 1890s and early 1900s. It was interdisciplinary at inception. Before the 1900s, most counselling was in the form of advice or information giving.

Development of counselling in the Global North

In the United States, counselling developed out of humanitarian concern to improve the lives of those adversely affected by the industrial revolution of the mid-to late 1800s (Aubrey, 1983). This development was influenced by the enormous influx of immigrants and the need for public education, social welfare reform movement and various changes in population make up. This could have been the genesis of the 'melting pot' phenomenon. Counselling at the time, emerged in the period of a major shift in the way individuals viewed themselves and others. Counselling was done by people who called themselves teachers and social reformers or advocates. The focus was on teaching children and young adults about themselves, others and the world of work. The counselling work was primarily concerned with child welfare, educational, vocational guidance, and legal reform. In their work, counsellors of the day concentrated on moral instruction on being good and doing right, and dealing with intra- and interpersonal relations (Nugent, 2009).

Later in the 1900s, Frank Parsons, who is regarded as the founder of guidance, developed the profession and focused his work on growth and prevention. He worked with Jesse B. Davis and Clifford Beers Whiteley (1984). Certification of counsellors began in the 1920s, followed by the development of theories by the likes of Carl Rogers (person-centred theory) in the 1940s. Later in the 1950s, the American Personnel and Guidance Association (APGA) was formed, and more associations followed until the 1960s when counselling was developed as a profession. Most focus in this era was on societal needs due to the rise of three events: the Vietnam war, civil rights movement and the women's movement. Humanistic theories on societal needs were developed by Dugald Arbuckle, Abraham Maslow and Sydney Jourad. This era saw the development of behavioural counselling as well as the popularity of group movement. The 1960s saw the development of counselling ethics and licensure began in the 1970s. In the 1980s standardisation of training and certification was launched. This meant counselling was taken as a distinct helping profession. The 1990s saw the birth of the American Counselling Association (ACA). Counselling in the 21st century was inclined to the needs of clients and society, for instance, dealing with violence, trauma and crises.

Development of counselling in the Global South

Brief history of counselling in South Africa

In South Africa, the term the counselling profession is also known as counselling psychology. The profession developed due to the country's socio-political history and the impact of apartheid (Bantjes et al., 2016). It was meant to promote the career development and

psychological well-being of the White Afrikaans speaking population. Counselling psychology was first recognised in 1974 (*Government Gazette*, 1974). Recently, the South African government has made efforts to ensure guidance and counselling provision to all people, especially the vulnerable populations. The South Africa Qualifications Authority (SAQA) ensures that guidance and counselling practitioners are appropriately qualified and registered with the relevant professional bodies (Moodley, 2021). There are various professional bodies in South Africa that include the South Africa Council for Educators (SACE), the Health Professions Council of South Africa (HPCSA) and the Psychological Society of South Africa (PsySSA). These ensure the regulation of the practitioners (Moodley, 2021).

Brief history of counselling in Zimbabwe

In Zimbabwe, counselling dates to pre-colonial times. Informal family-or kin-oriented counselling was common among the Zimbabwean populations (Mpofu et al., 2015). Counselling practice at the time revolved around education and training for life skills at every stage of human development (Chakuchichi & Zvaiwa, 2010). Senior people in the family and community were the counsellors who would assist those who needed help (Mpofu 2011). Chakuchichi and Zvaiwa (2010) also alludes to the participation of traditional healers as counsellors. The traditional type of counselling consisted of advice giving and was not regulated in any way. It would be done at the referral of the senior family members. Later, facilitative counselling was assumed by social others (Mpofu, 2015). Before regulation of the profession, government departments and civic bodies (non-governmental organisations, NGOs) ran in-house counselling workshops to equip their employees with basic counselling skills to provide HIV and AIDS counselling (Mpofu et al., 2015). Colleges and universities later introduced counselling diplomas and degree courses, respectively (Mpofu et al., 2015). This became the birth of professional counsellors, who still faced the hurdle of lacking a professional body that would regulate them (Richards et al., 2012).

Regulation of counsellors in Zimbabwe

After lobbying for a long time for inclusion in the registers of Allied Health Practitioners' Council, the intention to open a register for counsellors was under way by 2017. This came to fruition on 31st August 2018 when the intention to open the counsellors' register under Allied Health Practitioners Council was published in the Government Gazette. The final opening of the register was finally published in the Government Gazette of 26 April 2019 (No. 6 of 2000).

The established register was known as the Counsellors Register. This meant that counsellors would operate legally in Zimbabwe.

Online counselling

Globally, many higher and tertiary institutions have adopted the e-learning mode or the blended learning model. Counselling programmes require work integrated learning which is meant to link tertiary students to workplaces related to their field of study. This entails that trainee counsellors must be supervised while they are on attachment. Supervision has existed for as long as talking therapy has. Most supervisors currently use online tools in their supervision, for instance, video conferencing, emails, file sharing, social media platforms and written feedback. All or most of the supervision can take place online, for example, if the supervisor and the student are separated from each other geographically (Situmorang, 2020).

Conceptual framework

Work integrated learning (WIL)

Work integrated learning (WIL) often interchangeably known as work-integrated, practice-based learning is an important aspect in the learning process of counselling students. Both conventional and open distance e-learners (ODeL) are required to attain hands-on experience in counselling. Work integrated learning (WIL) is an arrangement between two resource groups, namely an educational institution and an industry or a counselling organisation, to assist learners to develop functional skills that are relevant in the world of work (Olusola, n.d.). When attached to a counselling organisation, learners can integrate theory with practice and develop a repertoire of skills, behaviour and attitudes that are essential for their career path.

The concept of trainee supervision

Wilson, Davies, and Weatherhead (2016) describe supervision as "designed to offer multi-level support in an atmosphere of integrity and openness for the purpose of enhancing reflective skills, maximising the effectiveness of therapeutic interventions, informing ethical decisions and facilitating an understanding of the use of self". The BACP (2018) describes supervision as 'a specialised form of professional mentoring provided for practitioners responsible for undertaking challenging work with people". Supervision is provided to ensure standards, enhance quality, advance learning, stimulate creativity, and support the sustainability and resilience of the work being undertaken (BACP 2018a). Being supervised when one is in training thus becomes very essential. Supervision in counselling means that a trainee counsellor is monitored by another more experienced and qualified counsellor to review their counselling

practice with clients. Trainee counsellors are provided with professional guidance and growth. Bernard and Goodyear (2004) contend that supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative and extends over time. The ongoing process of supervision promotes ongoing counsellor self-awareness and self-assessment by supervisees. Although Nelson, Nichter, and Hendrickson (2010) noted that, historically, supervision has facilitated development through face-to-face modes, it appears that, regardless of the setting in which supervision is delivered, the purpose is the same. Hence, the use of on-line supervision on trainee counsellors during and after the COVID-19 lockdowns. Supervision enhances professional gate keeping.

Review of related literature

E-learning/online supervision

Electronic learning, or e-learning, is education based on modern methods of communication including the computer and its networks, various audio-visual materials, search engines, electronic libraries, and websites, whether performed in the classroom or at a distance (Gul, 2015; Liu, Wu & Chen, 2013).

Globally, training institutions were not ready for disasters such as the COVID-19 lockdowns that forced people to be confined indoors. Learning at all levels adopted the online model, which to some extent, benefited those who had resources meant for online learning. E-learning and blended learning models were adopted globally when physical contact was very minimal. Counselling, as a practical profession, adopts a work-integrated learning model in its training to acquaint learners with the work environment. This means that supervision is needed to ensure quality learning, apart from the face-to-face model. Online supervision has also been adopted to accommodate attachments in the diaspora and in times of disaster like the recently experienced COVID-19 lockdowns. Online supervision includes video conferencing, emails, file sharing, social media platforms, and written feedback.

The role of supervision

Supervision ensures monitoring of trainees' sessions by more experienced and qualified counsellors. This gives professional guidance and ensures there is professional growth. Trainees gain skills with real clients presenting 'real' issues. During supervision, trainees' sessions are evaluated and suggestions on improvement discussed. According to the British Association for Counselling and Psychotherapy (2018), supervision is usually a formal but

collaborative process that involves regular 'consultative support' where two or more people form a 'supervisory alliance' with shared objectives about how to work together constructively. This provides a safe, ethical and competent service to the clients. In supervision, all things being equal, there is usually consultation of trained and experienced supervisors. On some occasions, 'peer supervision' is undertaken before the actual supervision. It is always important to ensure that competent and experienced practitioners are assigned the supervision role. In this way, their additional skills and knowledge ensure good practice.

When supervision of trainee counsellor is effectively done, the support they are given ensures that they stay grounded and maintain professional and ethical boundaries. Ethics are the guiding principles that a counsellor is required to uphold when dealing with clients. Most important is confidentiality, which is considered the cornerstone of this 'helping profession'. Apart from being conversant with professional and ethical boundaries, supervision of counsellor trainees ensures that trainees develop both theoretical and practical knowledge. Psychological theories that make trainees understand and assess human behaviour are applied during work-related learning. During supervision, the trainee is assessed to ensure they can utilise their knowledge of these theories spontaneously and effectively. It is during supervision that assessment is considered on how trainees enforce self-care. This is an essential aspect of helping professionals to circumvent burnout. It is mandatory that counsellors find time to engage in activities that ensure they debrief and take care of their mental health after carrying 'burdens' of their clients. Overall, supervision enhances professional gatekeeping. Thus, supervision ensures that standards are upheld, quality is enhanced, learning is advanced, and there is stimulation of creativity in the learner. Supervision also ensures that sustainability is supported, while the trainee becomes resilient when undertaking mental tasks.

Supervision of trainee counsellors as an educative process

According to Watkins (2016), supervision contributes to two outcomes, namely reduction of supervisee anxiety, shame and self-doubt and better quality of therapeutic practice. Thus, the supervisors strive to embrace, empower and enhance the therapeutic potential of the supervisee with whom they have the privilege to work (Watkins, 2012). For the supervision to succeed, there should be positive supervision relationship factors that include:

a) A cogent supervisory rationale (adaptive educational explanation)
b) A supervisor who believes in the efficacy of supervision and the specific supervision that is being delivered

c) A supervisee who believes in the supervisory expertise of the supervisor and embraces the supervision being delivered
d) Utilisation of supervision actions that constructively engage the supervisee and provoke change (Watkins, 2016).

In addition, there are three aspects that Watkins (2016)outlines. These include allegiance, expectations and interventions. The assessments can be beneficial and effective when the supervisor and supervisee are cognisant of belief in the power of supervision, are capable of addressing and fulfilling expectations of both parties and when their interventions clearly correspond with the articulated supervisory rationale.

Why is supervision important for a trainee counsellor?

Supervision has at its core three main functions that are inclusive of:

1) Supervision as a valuable way of "checking in" with a more experienced practitioner thus supporting and ensuring counsellors stay grounded, maintain professional and ethical boundaries, develop their knowledge, both theoretically and practically, as well as focus on self-care to avoid "burnout“.
2) The trainee counsellors who can reflect on their own practices and gain an insight into their performance by discussing counselling sessions with a supervisor and getting feedback.

Supervision falls into three main areas, with ethics being the priority.

i) Formative (i.e., growth-based): the supervisor shares their experience teaching the counsellor.
ii) Normative (i.e., monitoring-based): the supervisor asks the counsellor to account and justify their work.
iii) Restorative (i.e., support-based): the supervisor offers support if the counsellor is struggling with an ethical issue or an aspect of their practice.

What happens during on-line supervision?

During supervision, supervisees express their worries and difficulties to their supervisor. This is when trainees discuss their knowledge gaps, difficult cases they encountered and dilemmas faced during their practice. When supervisees discuss what happened in a counselling session, their therapeutic relationships are explored in order to ensure good practice is developed. Areas of concern include the effects of gender on a counselling relationship, the effects of differences,

for instance, race, class, or disability upon the relationship, levels of openness between counsellor and client and whether there is a sense of connection or distance between them.

Theoretical understandings are explored and theory is linked to practice as alluded to in the previous section. The supervisor checks whether the supervisee is working ethically as dilemmas can occur. The supervisor also checks if ethical frameworks are being properly followed. The supervisee and the supervisor maintain appropriate boundaries in therapeutic and supervisory relationships. Such observation of boundaries is important to enhance the trainee's ability to dichotomise issues, especially on the separation of professional and personal mental baggage. Failure to dichotomise what happens during sessions and one's life can lead to burnout. In supervision there is an honest discussion regarding the relationship between a supervisee and a supervisor. The supervisor points out on aspects that have been well or badly handled and takes the trainee through the possible way the session could have been done better.

Working with the supervisor ensures that anything that is blocking the trainee from being fully present with clients and from being accepting, empathetic and genuine is checked. For example, aspects such as personal issues, irritation with a client, feeling afraid or uncomfortable with a client, race, religious and cultural differences between counsellor and client, sexual attraction and others.

Types of online supervision

Online supervision can take three forms that include individual, triads and group supervisions. The individual mode is a one-on-one supervision between the supervisor and the trainee counsellor as he/she is in a counselling session or reflecting on various counselling processes. Triads involve two or more trainee counsellors who become observers, noting down comments that would be discussed later. The other trainee would be the counsellor. This can be a form of peer supervision. Finally, there is the group supervision mode. This is whereby each trainee provides a brief general overview of the week's activities followed by a presentation of one specific item for discussion.

Benefits of online supervision

Online supervision gives the trainee the opportunity, especially those who cannot afford to be physically in an institution or who failed to get the chance for face-to-face tuition to be assessed (Martin et al., 2017). Integration of technology provides the means for individuals anywhere around the world to "log in" to join the supervision discussions. Thus, distance barriers are

overcome. There is flexibility and convenience as benefits of the online approach of trainee supervision. Trainees and their supervisors get the opportunity to participate in the supervisory process from any location. Such supervision allows for access regardless of geographic location. A supervisor who is also connected remotely can monitor the counselling session live. This can be possible with the advent of platforms such as Teams, Google Meet, Zoom and other online platforms that enable video calling.

The online model can be considered cost effective. Lengthy commutes and financial barriers associated with the transportation costs of driving to supervision is avoided. For open and distance electronic learning (ODeL) students, there is easy accommodation through online supervision given the flexibility of online approach.

Methodology

Research methodology is a central aspect of the study as it addresses what, how and why questions of data generation and analysis. The understanding of the importance and relevance of trainee supervision process and the impact it has on trainee, the learning institution, and the placement institution can best be explained through the interaction with the key stakeholders. To get the most out of the study of this calibre, qualitative research approach was utilised, with the support of the interpretivism paradigm. In the context of the study, qualitative approach is used to collecting, investigating, and interpreting data by observing subjects and what they are saying. Interpretivism argues that truth and knowledge are subjective, as well as culturally and historically situated, based on people's experiences and their understanding of them (Gemma, 2018). In this study, interpretivism was selected premised on the fact that the reality around the study is subjective and is socially constructed. However, researchers using interpretivism can never separate completely from their own values and beliefs, so these would inevitably inform the way in which they collect, interpret and analyse data. This may affect the validity of the study. This weakness is offset by the fact that interpretivism allows for the gathering of "deep" information and perceptions through inductive qualitative research methods such as interviews and observation, representing this information and these perceptions from the perspective of the research participants (Lester, 2020).

In carrying out the study, qualitative data collection and research instruments were maximised to get the most out of the study. The key instruments utilised in carrying out the study include observing behaviour, interviewing participants, and desk reviews (Creswell & Creswell, 2017). The researchers interviewed the key informants of the study through maximising on in-depth

interviews to gather relevant and critical information. To obtain such information, unstructured interviews were utilised to allow researchers much greater freedom to ask, in case of need, supplementary questions or omit certain questions if the situation so required (Kothari, 2004). Participant observations were used in the study to collect primary data based on the main advantage of the method, which is that subjective bias is eliminated, if observation is done accurately (Kothari, 2004). The researchers used the research objectives for guidance in the observations.

Since the study used qualitative research approach, data was analysed using thematic analysis. All the information that was used in the analysis was derived from all the research instruments that were used in the study. Variable measures and questions that were important to shedding light on the research problem were embedded in the interviews and the participant observations. The questions were asked in a manner that led to the generation of appropriate pro forma for the responses. The analysis was done by isolating each variable and the corresponding responses to identify whether the independent variables had contributed to the explanation of the importance of supervision of trainee counsellors. The presentation of the results exposed the interpretation of the outputs of the study. The results were presented in thematic form of the actual responses of the respondents.

The study adopted a mixed method approach to gather data from the students and the university supervisors. Archival records, questionnaires, interview guides and telephone interviews were used to gather the data.

Ethical considerations

In this study, the researchers observed ethical observations of anonymity and confidentiality. Information given was treated with utmost privacy (Kang & Hwang, 2023), especially concerning the identities of informants and institutions. Informants were not judged for shortfalls in their supervision, if any were presented. All participants were treated with dignity and respect. Kang and Kwang (2023) emphasise that poor anonymity and confidentiality strategies develop unprecedented and precedented harm to the participants and impact the overall appraisal of the research outcome. In light of this, the researchers in the current study had to ensure that such outcomes are prevented from the onset of the study by observing the two ethical considerations.

Results

Perceptions and actual experiences of on-line supervision

For internship and practicum, flexibility and convenience were reported as benefits of the online approach. There was an opportunity for trainee counsellors and supervisors to participate in the supervisory process from any location. The excerpt below indicates what participant 1(P1) had to say:

> I was not sure if I was going to finish my course within the stipulated time due to the pandemic. I was away from home where I could find an institution that would take me in, I knew no one and the institutions were not willing to take risks. I contacted the institution supervisor who suggested I find a client whom I would counsel online.

Regardless of geographic location, there was access to clients online, and a supervisor who was also connected remotely was able to monitor the counselling session live. This was articulated when supervisor 1(S1) reflected her experience with online supervision:

> I had to be creative to assist the trainee. Sometimes one needs to think 'out of the box.' At first, I couldn't figure out how I would advise the trainee on ethical considerations. It was new to me as the mentee. It was difficult to convince the client to appear on screen, you know, but we succeeded anyway.

It was noted that the mode of supervision was also cost effective in reducing lengthy commutes and financial barriers associated with the transportation costs of driving to supervision sites. Supervisor 2 (S2) had this to say:

> Funds were difficult to obtain for travelling to the attachment site so I had to make do with online supervision after taking care of all ethical issues that would arise with video conferencing. I beat both the cost and the distance, and the work was done.

The trainee hailed online supervision that she experienced as a very effective way of serving on costs that could be incurred and the time for planning a physical visit:

> P2 - I thought my academic supervisor would fail to assess me when he mentioned the constraints that the institution had on conducting the physical supervision. I had lost hope of completing the semester course on field work. I was amazed by how interesting and creative online supervision can be, but you need efficient connectivity and data bundles that can sustain you.

For the ODeL students, there was easy accommodation through online supervision given the flexibility of online approach. Those who managed to engage online were able to avoid missing a semester of their tuition. Supervisor 3 (S3) narrated her experience thus:

> I had been attending those webinars on counselling supervision that are done online during COVID-19. It helped me to create platforms for my students when supervision was due. Both of us would not miss our roles and trainees seemed to perform better unlike the physical supervision which makes them develop cold feet when they feel your presence in the room.

The virtual environments were perceived as empowering counselling programmes that serve individuals from all over the country and even the world to participate in synchronous supervision. Social media platforms such as WhatsApp are convenient for individual and group supervision. Supervisor 4 (S4) had this to say:

> I could not connect on either Zoom or Teams platforms, I just had my iPhone for the task. The trainee just had her smart phone, but supervision needed to be done with minimal resources. We connected on a video conferencing call on WhatsApp, and it was done!

P3 had this to say:

> Where I was attached, there was weak connectivity, and I was not computer literate. I could not be able to connect on these modern online platforms such as Teams or Zoom. We are used to the WhatsApp platform so when my academic supervisor suggested the WhatsApp option, I was relieved that my journey would have a happy ending. It is expensive to repeat a course twice, I couldn't afford that!

Online individual supervision has proved convenient as the supervisor observes the trainee counsellor in session (client consent is sought in all cases). According to ACA (2014), counsellors, supervisors, and supervisees must provide informed consent from clients, The informed consent explains the purpose of the relationship, roles of the individuals involved, and the parameters of the roles (Kaplan et al., 2017).

Group supervision that was done on WhatsApp video calls, on Teams, Google class, electronic mailing lists and other platforms proved to be effective.

One participant from Group counselling 1(G1) enjoyed participating online for their group assessment:

> Our academic supervisor improvised a way to assess a group of counsellor trainees from different sites. She organised a day and time when this could be done. It was so interesting and effective because we met online and shared experiences. We got connected to other trainees whom we had not physically met since we are on the ODeL model.

Group supervision proved to bring lived experiences and increased collaboration among students on attachment. Across the globe, groups are enriched from the diverse experiences from trainee counsellors on attachment. Individuals from diverse cultures can be joined

synchronously to a classroom to share experiences of working with diverse clientele. These foster increased collective self-esteem. In this study, stronger case conceptualisation skills were also reported as a positive outcome.

Challenges

Globally, this mode of supervision can be considered a blessing when all things are equal. Owing to limited internet access and power outages in Zimbabwe, this mode of supervision can be difficult to execute. Intermittent breakdown in connectivity can disrupt a supervision session and make the assessment inconclusive. The issue of confidentiality can also be a concern where the system does not ensure privacy of sessions shared through online platforms. Hacking of the system might make clients decline being counselled on video call where their anonymity is not ensured.

Some learners are not techno-savvy enough to participate in online counselling sessions. Thus, in the Zimbabwean learning environment, most trainees might not have access to computers and their computer skills can be so minimal that they might fail to participate online. Only those who may be in the diaspora where technology is advanced might fully benefit from online supervision.

Cultural misunderstandings might also impede the success of online supervision. Where non-verbal cues are concerned, it might be difficult to understand behaviours of clients from diverse cultures since a trainee might access clients from multicultural societies that the supervisor could not be conversant with. This can also be vice versa as the trainee might also encounter a client whose culture is complex, and this could lead to misunderstanding one another. Online supervision with no visual components lacks nonverbal cues, which are evident in face-to face supervision. Where a call is involved, information about age, physical disability, or gender, may also be unverifiable due to the absence of visual cues.

Conclusion

The findings revealed that students had to find their own way of getting assessed and some postponed their studies due to lack of placement in the appropriate organisations. For those who got placement at their workplaces, the training was not as vigorous as it should be. Training institutions were not prepared for global emergencies such as the COVID-19 pandemic. For those who got online supervision, supervisors had to be creative to find strategies that would make them fulfil their duty to the trainees. It was realised that, although

trainees appreciated online supervision, it would mostly benefit trainees who could afford data bundles since institutions were caught unawares by the pandemic and had not budgeted for such. Those who were in the remote areas had connectivity challenges that would not make online supervision effective. Due to power outages, online supervision could be disrupted, and online supervision became a challenge to both the trainee and the supervisor.

Recommendations

Based on the findings of the study, it is recommended that:

i) Ensure there are enough budget to cater for work related learning and supervision to provide data bundles as a contingent measure for online supervision of trainees on industrial attachment

ii) Electronic gadgets should be part of students' package acquired from the institution where they are enrolled.

iii) Training institutions ought to go full throttle to find innovative ways for student supervision to continue flawlessly in this 4th Industrial Revolution.

iv) Institutional strategic plans ought to include resources and programmes for such emergencies

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Looking Back Mapping Forward: Navigating Healthcare Terrain Post-COVID–19 Period

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Abstract

The COVID–19 pandemic presented significant challenges to healthcare systems worldwide necessitating a proactive and strategic approach to navigate the post–COVID-19 healthcare landscape. This research paper delves into multifaceted challenges that healthcare systems face in the aftermath of the pandemic and emphasises the importance of equitable sustainable and ethical policy making. The research highlights the persisting mental health burdens, the long-term effects of COVID-19, the threat of antimicrobial resistance, strained healthcare infrastructure, healthcare provision disparities, climate change impacts, the influence of inflation on healthcare, the integration of artificial intelligence and the specific challenges related to aging populations. To address these challenges effectively, policymakers must focus on developing policies that ensure equitable access to healthcare services, facilitate sustainable healthcare practices, uphold ethical standards, encourage collaborative efforts among policy makers, healthcare providers, researchers and communities. Such an approach is essential for successfully navigating these post-COVID-19 healthcare challenges. By adopting a comprehensive and proactive approach, healthcare systems could work with efficacy.

Keywords: policy making, healthcare challenges, artificial intelligence, health disparities , inflation in healthcare, resilient healthcare, inclusive healthcare.

Introduction

The COVID-19 pandemic has presented significant challenges to healthcare systems, especially in resources constrained countries where healthcare delivery deteriorated significantly. Resource constrained nations across the globe found it difficult to cope with impact of the COVID–19 pandemic. The already weakened healthcare systems in developing countries in Africa, particularly Zimbabwe, faced unfathomable deterioration of service delivery due to the COVID–19 pandemic. These countries now need to quickly adapt frameworks to this new context. The COVID–19 outbreak led to unprecedented loss of lives with devastating impacts on societal and individual health. As a result, this paper argues for

the need for a proactive and strategic approach to navigate the post-COVID-19 healthcare landscape.

Methodology

There has been limited scholarship on strategies for navigating healthcare post-COVID-19 pandemic in developing countries. Studies on the phenomenon remain very scanty, especially in Zimbabwe. Using qualitative content analysis of several published empirical studies on the COVID-19 and its impact on healthcare delivery, this paper sought to assess strategies for navigating healthcare post-COVID-19 pandemic in Zimbabwe. Hsieh and Shannon (2005) define qualitative content analysis as a research method for the subjective interpretation of content of a text data through the systematic classification process of coding and identifying themes or patterns. Patton (2002) asserts that qualitative content analysis refers to any qualitative data reduction and sense-making efforts that take a volume of qualitative material and attempts to identify core consistencies and meanings. This type of design is usually appropriate when the existing theory or research literature on a phenomenon is limited.

Mayring (2000) asserts that content analysis uncovers patterns themes, and categories important to social reality. The method analyses social phenomena in a non–invasive way, in contrast to simulating social experiences or collecting survey answers. There are unlimited number of materials such as journals, books, papers and other relevant sources on COVID–19, but the majority of the materials can be traced from the advent of the pandemic in 2019 to as recent as 2024. Classical literature was also analysed. The researcher used themes as a unit of analysis. The results and discussion of the finding are therefore based on the defined unit of analysis (themes).

Results: Interpretation and synthesis

Using a qualitative research methodology, this paper reviewed and drew insights from extant literature to demonstrate that current conceptualisations and approaches to coping with pandemics and disease outbreaks in Zimbabwe were inadequate. There is therefore a need to give attention on how to navigate healthcare post-COVID-19. Results of the study were an unexpected scenario of the predominance of the indigenous knowledge system, the socially constructed nature of community resilience and rejection by local communities of norms and values prescribed as a panacea to the pandemic but perceived by them to be alien and antagonistic to their socio-economic cosmology. Insights from this study assisted in the development of a map for the road ahead in terms of healthcare post-COVID-19 (actionable

public health guidelines). As a point of departure and to demonstrate an appreciation of how the road ahead is supposed to be, we need to have an appreciation of how the road ahead is supposed to be, we need to have an appreciation of the success stories, if there were any, of the COVID-19 pandemic prevention protocols adopted by the authorities. An interrogation of these strategies would provide valuable insights in shaping and forging the new road ahead in healthcare delivery.

Strategies adopted by authorities to deal with COVID-19 and vital insights for the future

In efforts to stem the tide of the pandemic, the government and all active stakeholders in the fight against the pandemic activated several communities to disseminate information about the pandemic to caution the public.

Communication

The synthesis of extant literature on COVID-19 pandemic illustrate a plethora of communication strategies used in preparing countries for the impeding COVID-19 pandemic as well as at the height of the pandemic. A scan of extant literature indicates various communication strategies that the countries employed in the preparation for pandemics (WHO, 2020; Huang, 2020; Haslett, 2020). As the national governments escalated their authority during national disasters or emergencies, effective communication strategies became progressively important for fighting plagues and stabilising society (Huang, 2020).

Media coverage of a possible COVID–19 pandemic has the potential to either accurately and successfully inform the public or to mislead and cause unwarranted public alarm and unfavourable reactions (Kim & Kreps, 2020). Evidence from the study findings highlighted several communication platforms used to inform the public of the impending COVID–19 pandemic. Some of these communications strategies included the radio, televisions, social media platforms such as WhatsApp and texts, the print media, health workers, amongst a host of others.

Generally, it can be said that the communication strategies initially achieved success in terms of communicating the intended messages. However, they failed to lead to the anticipated behavioural changes due to other challenges to do with the state of livelihoods as the majority lived from hand to mouth. WhatsApp was used by communities to stay in touch with loved ones, get information about the pandemic, among a number of other uses. Social media platforms thus played an important role in authorities' communication with citizens as the

pandemic led to a narrowing of the topic agenda on these platforms, with an increased level of WhatsApp activity by political and health experts (Rauchfleisch, Vogler & Eisenegger, 2021). Even print media such as newspapers and pamphlets were central in relaying information about the pandemic.

Over time, there was a lot of infodemic as almost everyone had a right to relay messages about the pandemic to the public causing panic and fear. The absence of a centralised and regulated platforms contributed to the recorded rise of infodemic, which was characterised by widespread misinformation, deception and so-called "fake news", which hindered the adoption of protective personal actions.

Vital communication strategy insights for mapping healthcare post-COVID-19

The COVID-19 pandemic triggered a need for a proper and fact-checked reporting. The need for proper fact checking and reporting was further heightened by social media networks that also added some elements of misinformation or fake news circulating about the pandemic (Mututwa & Matsilele, 2020). During the pandemic, the media were a conduit for communication from public officials and experts to the broader public (Perreault & Perreault, 2021) and, in turn, playing a facilitative role (Christians et al., 2010). Effective communication guides the public, health providers, and other groups in responding appropriately to outbreak situations and complying with public health recommendations (Reynold & Quinn, 2008). Thus, it can be constructed from the above findings that responding to COVID-19 pandemic reporting required critical preparedness and responses, that is, including effective communication as an essential strategy.

Evidence from the study highlights that marginalised communities and the vulnerable members of society, especially in the remote rural communities, found it difficult to access both print, television and social media platforms. The print media is regarded as expensive and, in some areas, remain largely inaccessible. Hence, the use of print media in information dissemination saved its purpose only to a limited number of people, especially those in urban communities, whilst the rural communities were left lagging behind. Dube et al. (2021) also share similar misgivings about over-relying on print media to disseminate important information to the public such as that of the impending pandemic. It can therefore be construed that the print media, as a communication strategy, should be part of an integrated communication framework rather than a solitary approach.

There is a need to have customised communication channels for the different strata of society at large. Effective communication can lead to more constructive management of fear and anxiety that may emerge because of a global health pandemic. This could only be possible with freedom of the press. By ignoring effective communication, newsrooms left gaps for vulnerable people and made the COVID-19 epidemic harder to contain. Therefore, it makes sense to contend that efficient government communication influenced the propensity of people to use self–defence healthcare measures and, in turn, reduced deaths in large proportions. The evidence of fewer deaths and more citizen adoption of self-protective behaviours should be used to gauge the "success" of a communication campaign. After such a post-mortem of communication strategies, insights on the most effective strategies can be mapped out for future use.

Furthermore, messaging needs to address community risks (e.g., disproportionate impact on racialised communities) and be framed in a way that is culturally relevant to the target audience (Airhihenbuwa et al., 2020). Drawing on behavioural insights and social sciences can serve as a starting point for communication strategies that target specific behaviour change interventions. Protocols should take into account the livelihoods of the communities for which they are made.

Discussions

In order for any healthcare prevention protocol to work, it has to be communicated to the recipients in a timely and effective manner. Evidence from the study illustrate communication challenges that affected efforts to mitigate the spread of the pandemic. A close analysis of extant literature on COVID-19 points towards several obstacles that militated against the effective dissemination of information on the pandemic. Viral social media platforms contributed to the recorded rise of infodemic, which was characterised by widespread issues of misinformation, deception and so-called "fake news". This hindered the adoption of self-protective healthcare actions. Effective communication guides the public, healthcare providers, and other groups in responding appropriately to outbreak situations and complying with public health recommendations (Reynold & Quinn, 2008). Thus, it can be construed from the above findings that responding to COVID-19 required critical preparedness and response, which includes effective communication as an essential strategy.

Evidence from the study highlight that soon after the adoption of lockdown, Zimbabwe was confronted a triple threat of the COVID-19 pandemic, food shortages and economic meltdown.

This effectively forced people in the informal sector to defy state-gazetted lockdown regulations in order to avoid starvation. Hence, from the findings, it can be concluded that there when navigating health post-COVID-19, there is a need to consider the livelihoods of the local communities for which the disease prevention protocols are being designed. The enforcement of government pandemic prevention protocols affected everyone, however, they had more negative impacts on the most vulnerable members of society. The ability to abide by the protocols was clearly determined by economic needs. Some individuals thought there was a hierarchy of needs within communities and these were shaped by financial resources that influenced who was able to follow prevention measures and protect themselves. As Mukeredzi (2020) argued, "If vendors and other self–employed workers are barred from leaving their homes to ply their trade, how are they to feed their families?" Informal workers were therefore forced to defy state lockdown regulations and resume informal activities in order to survive. For some, 'survival' was a matter of life and death; for others it was more a crisis of accumulation.

General recommendations for navigating healthcare post-COVID-19

(i) Improving communication strategies.

(ii) Ensure that the design and implementation of any healthcare disease prevention strategy considers the existing livelihoods of the local communities for which with they are designed.

(iii) Integrate IKS into healthcare practices as most communities, especially those in rural areas cannot afford the modern disease prevention protocols such as drugs.

(iv) Authorities to move away from the "copy and pasting" kind of strategy in handling disease outbreak, but design prevention practices that are culturally embedded.

(v) Ensure coordinated approaches in strategy implementation in disease outbreak handling (who does what/ proper delimitation of duties).

(vi) Provide adequate funding to the health sector.

(vii) Efforts should be directed toward building health system resilience through local, national and global engagement and improving healthcare financing.

(viii) African countries, Zimbabwe included, should focus on a coordinated approach to build capacity for vaccine development, transport and roll-out of vaccination for healthcare professionals and high-risk individuals, including those in rural areas.

(ix) High-quality time-trend analyses are needed to understand better the extent and nature of on-going changes and responses of the African health systems to the pandemic.

(x) Post-COVID-19, healthcare systems need to assess and strengthen their infrastructure, capabilities, and human capital to be better prepared for future healthcare emergencies and actual burdens.

(xi) The pandemic has highlighted existing health disparities and inequalities in access to healthcare services. COVID-19 health inequalities persist globally, with marginalised and disadvantaged populations facing disproportionate health burdens. Post-COVID-19, healthcare systems ought to address these disparities, particularly among marginalised communities, to ensure equitable access to healthcare and reduce health inequalities.

(xii) There is a need to improve healthcare policies. Addressing social determinants of health reducing health disparities and promoting health equity requires comprehensive policies and targeted interventions (Puska, 2007).

(xiii) Comprehensive approaches could also include initiative of education and skill-building programs, affordable and safe housing programmes, economic development and employment opportunities, accessible transportation, nutritious food access, income, Special support, poverty reduction, community empowerment, and engagement.

(xiv) Implementing policy/ strategy review. There is a need for data-driven approaches and evaluation to improve on the healthcare programmes and policies. Data reporting allows for comparisons and benchmarking across provinces. Data reporting allows for comparisons and benchmarking across provinces, enabling evidence-based decision making and accountability.

(xv) Mitigating the negative impacts of climate change. Mitigating climate change and building resilience in healthcare systems are crucial for protecting public health and ensuring sustainable development.

(xvi) Managing inflation to reduce the burden on society in acquiring healthcare services.

(xvii) Initiating health support for the elderly.

(xviii) Many countries have fragmented healthcare systems with multiple stakeholders, such as government agencies, private insurers, healthcare providers, and pharmaceutical companies. Coordinating and aligning the policies of these diverse entities can be complex and challenging.

(xix) Policies must adapt to new treatment options, diagnostics, and digital health innovations while ensuring their safety, efficacy and accessibility to all individuals. Special attention is needed from policy makers regarding the ethical challenges associated with the fast development of medical technology. Laws, rules, regulations, and policies must be regularly adjusted. Again, with the increasing use of electronic health records and digital health platforms, ensuring the privacy and security of personal health information becomes critical (Zaguia, 2023).

Conclusion

The pandemic exposed the inadequateness of healthcare systems across the globe, particularly in developing countries like Zimbabwe. As a result of the COVID-19 pandemic, healthcare plans are facing a difficult road ahead. Health plans are currently focused on safe operations, directing scared and vulnerable members to the right care options, and helping.

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Post-traumatic Stress Disorder (PSTD) of Health Professionals Post-COVID-19 Period: Insights from Zimbabwean Nurses

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Abstract

The focus of the study is to highlight post-traumatic stress disorders for Zimbabwean nurses in the post-Covid-19 period. In this study, Bandura's social cognitive learning theory was used to understand the research phenomenon. The social cognitive learning theory of Bandura entails that compassion fatigue is more common in people who work in professions where they are tasked with supporting people who have experienced trauma. Bandura's vicarious capability has it that human beings learn through experience and observation, and that, through over exposure to people in trauma, the healthcare giver experiences similar mental health issues. This is common among nurses. Continual exposure to other people's trauma can take a toll on nurses who, resultantly, become vulnerable to mental health issues. The study used mixed method approach that puts together quantitative and qualitative methods to collect and analyse data. Nurses in Shurugwi were the population from which convenience sampling technique was used to draw a sample of forty participants. Structured questionnaires and semi-structured interviews were employed to collect data. Results of the study indicate that nurses were on the frontlines during the pandemic and thus faced high levels of stress, anxiety, and burnout as they cared for critically ill patients and witnessed the devastating impact of the virus. Many nurses experienced symptoms of trauma and PTSD, which could have long-term effects on their mental health and well-being. Consequently, health professionals may also experience PTSD with physical health consequences such as high blood pressure, cardiovascular diseases, and chronic pain due to the prolonged stress and trauma they have experienced. The remedies suggested in the study include the enhanced awareness of the mental health of healthcare employees, especially by hospital administrators and authorities. During disease outbreaks, healthcare workers ought to be aware of their vulnerability to stress. Psychological well-being of healthcare workers should be promoted by hospital support systems and occupational health policy. Counselling is important for managing and promotion of wellness programmes for health workers.

Keywords: trauma, disorder, mental health, COVID-19.

Introduction

This study examined post-traumatic stress disorders among nurses in Shurugwi, Zimbabwe, so as to establish their coping mechanisms during the post-COVID-19 period. The onset of the Coronavirus in 2019 marked a rapid spread of the disease, leading to rapid transmission and high mortality , causing a significant psychological impact on the populace. Interpersonal relationships, daily work, and mental health were affected by the virus, which changed our everyday life. The emotional and psychological effects of COVID-19 affected all members of society including nurses. PTSD is a mental health challenge experienced after having been exposed to trauma. It has negative effects, especially when not addressed. The study sought to explore PTSD among nurses in the post-COVID-19 period.

Background to the study

Healthcare professionals experienced anxiety, depression and PTSD during and after the outbreak, according to previous research on other infectious diseases (Lasalvia et al., 2021; Bonetto et al., 2022). The necessity to carry out this study was due to the possibility that health professionals (HPs) also experienced post-COVID-19 PTSD. Furthermore, nursing provides the largest occupational group that is in constant contact with their patients.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) describes traumatic exposure as a traumatic event, accompanied by symptoms in four categories: intrusion, avoidance, negative changes in cognitions and mood, and changes in arousal and reactivity (American Psychiatric Association, 2022). Maunder et al. (2020) studied these risks in the HPs population during the 2003 SARS outbreak. Their habits of smoking and drinking increased, they experienced burnout and distress, and they lost interest in interactions with their patients. During the recent COVID-19 pandemic, health professionals were in direct contact with patients, taking care of several potentially infectious people, and experimenting with physical and psychological pressure (Guo et al., 2020). The medical professionals offer care to and share concern with their patients. Such roles are overwhelming and, as a result, some nurses could have developed PTSD in the post-COVID-19 period. A similar study on the impact of the 2014 Ebola virus and the 2015 Middle East Respiratory Syndrome MERS outbreak has shown that some nurses experienced high levels of emotional stress, anxiety, depression and post-traumatic stress.

Factors that lead to PTSD among nurses in the post-COVID-19 period

The epidemic caused significant changes regarding the economy, family and social life, but it remains unclear how these changes encompass the emotional and psychological symptoms of nurses in Zimbabwe. Preventing PTSD in healthcare workers exposed to the COVID-19 pandemic was a challenge world-wide. Due to their exposure to patients, healthcare workers were likely to experience acute and chronic, often unpredictable, occupational stressors leading to PTSD. According to d'Ettorre et al. (2021) the psychological impact of COVID-19 on healthcare workers represents a special challenge for healthcare systems throughout the world. Nurses represent the first line of fighters treating patients with COVID-19, and every day they were faced by a high risk of being infected and spreading the virus to their families and other people.

A body of evidence highlights that past infectious disease outbreaks, including the severe acute respiratory syndrome (SARS), the Middle East respiratory syndrome (MERS), and the 2009 novel influenza A (H1N1), were associated with mental health issues among health workers (HWs), mostly post-traumatic stress symptoms (PTSS). Research by Xiao et al. (2021) revealed that healthcare workers employed in environments prone to SARS were two to three times more likely to have elevated PTSS levels than those not exposed. As has already occurred in past outbreaks, the post-COVID-19 period is also highly likely to expose nurses to PTSD.

The nurses' risk of suffering from symptoms of post-traumatic stress disorder increased as a result of their efforts to continuously fight several COVID-19 related conditions. This study on PTSD among nurses in the post-COVID-19 period focused on the health delivery system's intervention strategies, and sought to highlight the characteristics of the pandemic-related traumatic experiences.

As new pathogens are discovered, the prevalence of infectious diseases increase, posing enormous challenges for society regarding disease control (Esposito, 2016). The high level of stress, anxiety, and depression experienced by medical personnel during the SARS epidemic, according to a survey, may have had a lasting psychological impact (Preti et al. 2020). Extreme physical and psychological challenges have resulted due to these intense and highly controlled working environment. Work has become more challenging for nurses due to variations in working intensity and the working environment while providing assistance during disaster (Theoreli, 2020). This investigation in Zimbabwe sought to highlight factors that trigger

medical professionals to develop post-traumatic stress disorder (PTSD) following the COVID-19 pandemic, and suggests coping strategies.

The nature and context of problems affecting the well-being of nurses and the health delivery system

According to Yung (2020), healthcare workers often wonder how to strike a balance between their moral obligation to care for patients and their fear of contracting the disease and passing it on to their loved ones. Nurses face challenges in balancing their own well-being and professional obligations. Banerjee (2020) has it that sometimes healthcare workers find themselves in situations where they might have to make the agonising decision of depriving ventilator support to critical patients who are unlikely to survive, and to allocate it to less critical patients with better chances of survival.

As reported in an Italian study, the vulnerability of colleagues and family members was a major cause of concern for HPs (Rossi 2020). Anxiety was a concern, particularly in the majority of the COVID-19 studies. Anxiety is a state of not being certain of the next moment.

The most important factor in healthcare workers with high anxiety, according to Kang (2019), was being suspected of having COVID-19 infection, especially compared to those who were not suspected. Nurses in China reported that a lack of protection against the disease and difficulties keeping up with daily changing knowledge/or skills contributed to fear. Naser (2020) states that the fear of transmitting COVID-19 led many health professionals to isolate from their families for months.

Intervention strategies available to promote the provision of coping mechanisms for nurses suffering from PTSD

Rummer (2020) asserts that leaders need to be aware of the extent and sources of stress among healthcare workers during disease outbreaks. Hospital support systems and occupational health policy should therefore promote the psychological well-being of healthcare workers. Improving the understanding of nurses' fears and the factors associated with those fears would be helpful to people involved in response planning for future outbreaks of infectious disease. To manage such situations, counselling is important. Saeb (2020) mentioned that stigmatisation of nurses affected by mental health problems can be minimised through an integrated administrative and psychosocial response to challenges that are caused by outbreaks. Health delivery system that involves counselling services for the healthcare workers create a safe and secure environment. The risk of mental health problems during the COVID-19 outbreak was

lower for healthcare workers who utilised mental healthcare services, according to Kang (2020).

Marimbe et al. (2016) assert that an understanding of care givers' experience with chronic stress is necessary for designing culturally appropriate support structures for them. Many participants pointed out their core beliefs and the meaning they attached to their work as being stressful. In Zimbabwe, caregivers require support from healthcare organisations to help them deal with stress and taking care of their clients with minimal adverse impact on their own mental health.

According to Smith et al. (2022), social support plays a critical role in resilience. Application of this knowledge to development and optimisation of preventive interventions requires knowledge of how to extract social support benefits and prevent harm. Bandura's social cognitive theory of stress adaptation examines how social environments influence resilience. High rates of burnout, job turnover, psychiatric distress and suicide risk are some of the mental health problems that preceded the pandemic.

Social harms can be difficult to avoid due to misguided, ineffective, or even negative or invalidating reactions from members of HPs social networks (Khan, 2021). Key innovation is represented by community level intervention programmes such as greater resilience information toolkit (GRIT). The toolkit was designed to empower the social system of the community or healthcare unit to respond to threatening and changing environmental demands so as to increase the care that communities and social networks can naturally provide (Shechter, 2021). This would raise the baseline level of resilience. It was therefore important to conduct this study so as to establish the coping mechanisms of nurses to PTSD in the COVID-19 period. Subsequently, mental health challenges among healthcare professionals could be reduced by caring and supporting them after COVID-19. This would enhance the health delivery system's capacity to deal with future outbreaks. Communities can be hopeful and resourceful with counselling.

The study employed the social cognitive learning theory. This is based on the understanding that people learn from interactions with others in the social context. In their caring role, nurses observe patients in trauma, some with chronic illnesses and some dying. COVID-19 made the caring role intense and, in the process of being empathetic, nurses could not avoid compassion fatigue and burnout. According to Figley (2022), compassion fatigue is more common in

people who work in professions where they are tasked with supporting people who have experienced trauma. This is common in nurses. Continual exposure to other people's trauma can take a toll; consequently, nurses become vulnerable to mental health conditions. Even when the nurses want to empathise, they may find that they simply do not have the emotional and physical resources to do so.

Compassion fatigue involves emotional and physical exhaustion that can affect people who have been exposed to other people's traumas and stressors. It is characterised by a decreased ability to empathise, feelings of helplessness, and burnout from supporting those who are suffering.

Research Approach

Mixed research refers to a research approach that involves blending qualitative and quantitative approaches as well as tenets of other paradigms (Johnson & Christensen, 2014). Given the nature of the study phenomenon, a mixed research approach was found to be suitable because it helped to improve the quality of research by mixing up the strengths of both qualitative approach and quantitative approach. The main strength of mixed research, according to Johnson and Christensen (2008), is its ability to apply its findings to other populations. A mixed approach has been found to be useful and appropriate since it requires the reduction of the phenomenon under study to numerical values, which calls for statistical analysis of data, as well as explanation and feedback, which calls for qualitative data analysis (Apuke, 2017). Subsequently, using quantitative approach only may prove to be futile in comprehending the perspective in which individuals act. Qualitative research makes up for this when using mixed design.

The sample size between 30 and 500 at the 5% confidence level was adequate for many social science researchers, according to Delice (2018). The minimum sample size suggested by Anaekwe is 10%. The sample size for this research was 40 participants, calculated using online sample size calculator at 95% confidence level. There is a 5% margin of error from a population of 300. This is true for QUAN as well. The size of the sample was determined at saturation point under QUAL (Creswell & Creswell 2018).

Kothari (2006) points out that structured questionnaires are incredibly easy to use and, above all, inexpensive to analyse. In this study, the researcher distributed structured questionnaires to 25 nurses from Shurugwi Hospital in Zimbabwe. Semi-structured interviews often contain

open-ended questions and discussions may diverge from the interview guide. The researcher interviewed 15 nurses from the hospital. ln total 40 health professionals participated in this study. This study used descriptive statistical tools such as tables, bar graphs, pie charts, and measures of central tendency tool to analyse data collected through the QUAN approach.

Interviews were recorded and transcribed manually by the researcher for data generated through the QUAL approach. Data gathered through semi-structured interviews was analysed via content analysis. Analysing and interpreting themes and sub-themes enabled the generation of meaningful data. The results from both approaches were compared to see if there were any convergences, differences, or combinations after the QUAN data analysis.

Results

Table 1: Demographic Data of Participants N=40

	QUALIFICATIONS		
Gender	**Diploma**	**Degree**	**Total**
Male	13(32.5%)	2(5%)	15(37.5%)
Female	24(60%)	1(2.5%)	25(62.5%)
Total	37(85.5%)	3(7.5%)	40 (100)

The participants understood the items in the instruments since they were all educated. The results can therefore be trusted.

Table 2: The Age Group of Participants N=40

	Age group					
Gender	Below 25	25-35	35-45	45-55	55-65	Total
Male	2(5%)	7(17.5%)	4(10%)	2(5%)	-	15(37.5%)
Female	3(7.5%)	10(25%)	8(20%)	2(5%)	2(5%)	25(62.5%)
Total	5(12.5%)	17(42.5%)	12(30%)	4(10%)	2(5%)	40(100%)

The selected group was composed of mature and energetic staff who still had many years in the health delivery system. This also implies that they had many roles and responsibilities. The effect of PTSD to this group revealed negative impacts to the well-being of the nurses and the health delivery system. The health delivery system suffers a lot if PTSD is not addressed.

Nature and context of problems affecting nurses over PSTD due to the COVID-19 pandemic

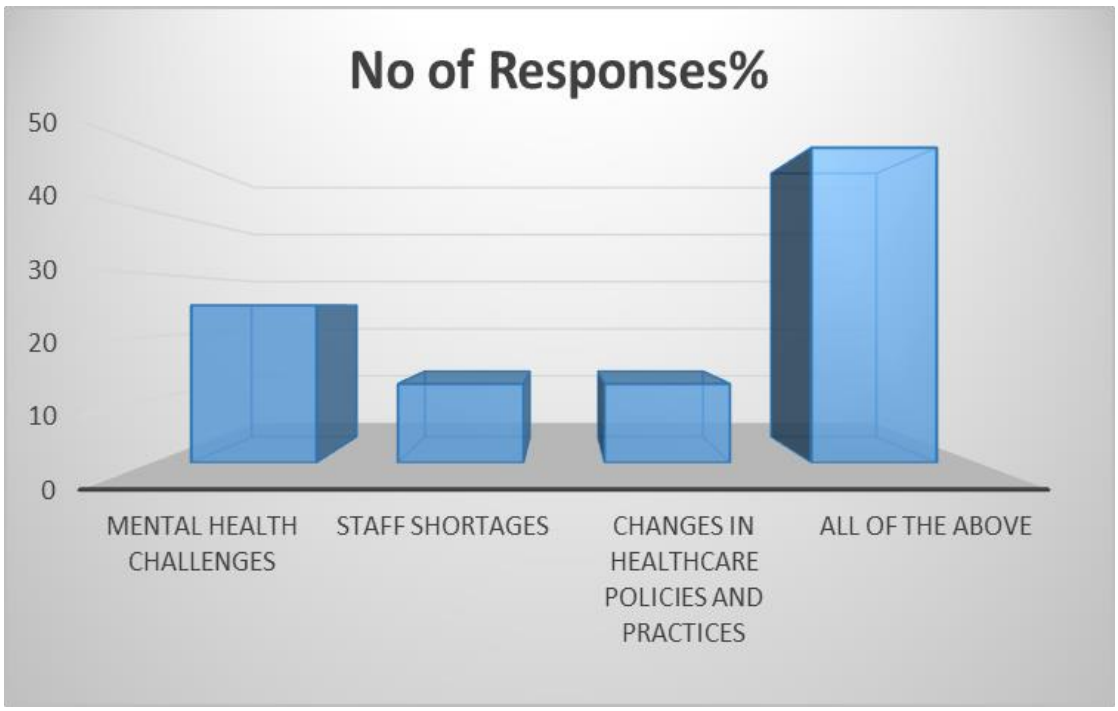

Figure 1: Nature and Context of the Problem

Nurses affected by PTSD due to COVID 19 pandemic

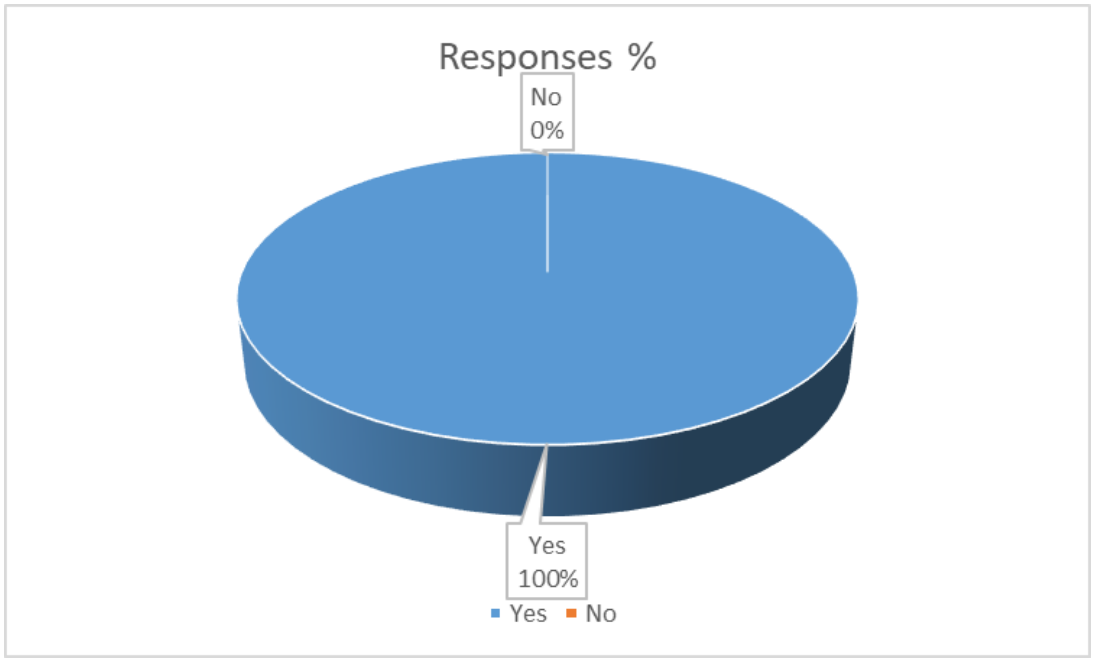

Figure 2: Nurses Suffering from PTSD

DISCUSSION

Factors affecting mental health of nurses during and after COVID-19

The research study found that nurses experienced PTSD as a result of having been exposed to patients. Due to the exposure to COVID-19 conditions, nurses were stigmatised both at work and in the community. The chances of infecting their family members were overwhelming for nurses in this study. This is in agreement with a study in Ghana that revealed that a substantial proportion of health workers faced stigma and discrimination related to COVID-19 (Ghana Health Service, 2021)). Stigmatisation of healthcare workers who are already vulnerable to infection due to increased exposure affect their concentration on work.

The investigation revealed a dearth of resources, such as personal protective equipment and counselling services, contributed to stress. This is in line with the findings of Harwood (2000) who found inadequate counselling strategies to be significantly associated with increased anxiety and depressive symptoms in healthcare professionals. A lack of counselling and personal protective equipment leads to compromised working conditions and increased exposure to infections. In addition, a lack of a proper sense of protection among health workers increase psychological distress and affect their mental well-being because a large proportion of COVID-19 cases are asymptomatic.

Nurses faced ethical dilemmas in their roles of caring for COVID-19 patients because of fear of contracting the virus. This is similar to a study by Yung (2020) that established that healthcare workers often have concerns about how to balance their ethical duty to provide care for patients against their fear of contracting the disease and transmitting it to their families. Nurses also struggle with balancing their own physical and mental health against the call of duty. They sometimes find themselves in situations where they might have to make an agonising decision of depriving ventilator support to critical patients who are unlikely to survive. They may allocate it to less critical patients with better chances of survival.

Stress among healthcare workers resulted from the employer's indifference. Many other essential drugs required to manage COVID-19, such as diazepam and morphine, and equipment such as pulse oximeters and syringe pumps, were in short supply (Kang, 2019). There are few other places that use concentrators instead of pipes for oxygen, which could lead to supply disruptions. The COVID-19 pandemic made the government of Zimbabwe realise how important it was to allocate resources to hospitals. The pandemic challenged the health delivery system to come up with multi-models to address the ever-changing health challenges that could

not be solved by the traditional linear model. The pandemic also called for counselling professionals to be accessible and visible in the health delivery system.

The study established that one of the causes of stress was emotional imbalance. The nurses were worried about spreading the disease. According to regional studies, many of them were isolated from their families for months because of fear of transmitting COVID-19. Loneliness was further exacerbated by working remotely and being shunned by community members. Fear of the unknown, becoming infected, and threats to their own mortality were some of the stressors that healthcare workers faced. This concurs with an Italian study by Rossi (2020) that being exposed to contagion was associated with symptoms of depression, while having a colleague hospitalised or placed in quarantine was associated with post-traumatic stress. Anxiety was a major concern, especially across most of the COVID-19 studies including this research. Anxiety refers to uncertainty regarding an upcoming event.

Effects of PTSD to nurses

The research study found that nurses were overwhelmed during the COVID-19 period, and they experienced compassion fatigue. This concurs with Figley (2022) who established that burnout and other forms of work-related psychological distress are unavoidable health concerns. People who work in the fields that deal with helping people who have been through traumatic events are likely to suffer from compassion fatigue.

The research study found out that nurses were affected by fear of contracting COVID-19. They felt insecure during the outbreak. The results concur with Nickel (2004) that, during the SARS outbreak, fear was primarily attributed to variables such as loss of control, concern for one's own health, and the spread of the virus. Clinical nurses are prone to psychological problems because of the many uncertainties. COVID-19 brought about many uncertainties even among nurses, and this left emotional scars including anger.

The study also established that nurses were depressed in the post-COVID-19 period as a result of having been exposed to traumatic working condition. Nurses are one of the largest occupational groups that are directly and intensively in constant contact with their patients. Another main reason for poor mental health in different studies was working in high-risk departments. The results of the study show that nurses suffered from mental health challenges in the post-COVID-19 period. Nursing is ranked 27th out of 130 jobs surveyed for mental health problems. According to survey, 7.4% of nurses were absent from work each week due

to burnout or disability due to stress, which is 80% higher than other occupational groups (Korea, 2019).

Intervention strategies

Researchers found that there are few specific intervention strategies to deal with PTSD among nurses after the COVID-19 pandemic. Although nurses were exposed to mental health issues, there had insignificant counselling support. Discrimination and stigma affect the levels of social support for healthcare professionals. The researchers discovered that effective strategies to manage stigma and discrimination are necessary in dealing with nurses PTSD. Their families and friends are worried about being affected, which results in relatively low social support. Steele (2020) stressed that, in order to effectively support nurses, the greatest assets of healthcare systems must understand their challenges and needs. The study established that occupational health issues, such as burnout and other forms of work-related psychological distress, are unavoidable. By acknowledging the commonality of psychological distress related to caring for patients with COVID-19, people can avoid stigmatisation of work-related mental health issues and appropriately attend to the mental health needs of all healthcare workers affected by the pandemic.

People who support those who are suffering, such as those who work in the healthcare professions, can become vulnerable to mental health issues if they are exposed to other people's trauma. Even when nurses want to empathise, they may find that they do not have the emotional or physical resources to do so. They may have feelings of helplessness and burnout due to the demands of supporting those who are suffering.

The research study found that working conditions were not favourable due to the shortage of staff and high volume of work. This concurs with Naser (2020) who established that hospital staff charged with admitting and caring for patients with COVID-19 were subjected to a variety of individual and organisational stresses that adversely affected their health and job satisfaction. Intervention strategies that reduce the workload would help nurses to deal with such stressors.

The study revealed that nurses were not aware of the stresses they were experiencing. Lack of awareness of stressors among nurses was found to be one of the obstacles in tackling post-traumatic stress disorder. Nurses were therefore not be able to connect their present experiences with the COVID-19 period. Counselling is important in such a situation.

Stress increases depression and anxiety, which can reduce job satisfaction, impair individual relationships, and even lead to suicidal thoughts. The diminution in concentration and decision-making abilities, as well as the mental health professional's poor capacity to communicate effectively with clients, can all contribute to lessening of psychological interventions. Stress management workshops on capacity building would help nurses deal with PTSD in the post-COVID-19 period.

PTSD affects nurses differently regardless of experience, and whether they have experienced similar conditions before. The treatment process is highly individual, and what works for one person may not work for another. At various stages in life, a person living with a chronic mental disorder may choose different options. The individual should work closely with a counsellor who can help them identify their needs and provide them with suitable treatment.

Counselling services were not provided to the nurses in Shurugwi during the pandemic. This is different from the assertion by Chimbwanda (2020) that, in Bulawayo, nurses were given new skills on management of stress, anxiety and depression during the COVID-19 pandemic. Health workers were trained to provide patients with psychosocial support and deal with issues of stress, discrimination, and fear in dealing with COVID-19. They learned how to handle bereavement issues and cope with the deaths of their co-workers and relatives, as well as how to spot signs of psycho-social or mental issues among their co-workers.

The investigation revealed that nurses were not educated regarding post-COVID-19 PTSD. Rummer (2020) suggests that there should be enhanced awareness among authorities or hospital administrators about their employees' mental health. During disease outbreaks healthcare workers need to be aware of the extent and sources of stress. Psychological well-being of healthcare workers should be promoted by hospital support systems and occupational health policy. Improving the understanding of employees' fears and the factors associated with those fears would be helpful to people involved in response planning for future outbreaks of infectious disease. Counselling is important for managing such situations, but it was not available for the sampled nurses in Shurugwi. This study established that the health delivery system in Shurugwi focused more on the patient and less on the nurse who is the care giver.

It is recommended that health professionals should be shielded from shaming and sexism. Sahebi (2020) acknowledges the importance of preventing nurses from being stigmatised, and policy makers should take steps to minimise this stress and allow them to focus on patient care.

An integrated administrative and psychosocial response to challenges that are caused by outbreaks could reduce stigma (Park, 2018). Education and advocacy for more respect for human rights and less stigma are ways to raise awareness about mental disorders.

In critical situations where face to face contact increases the risk of infection transmission, information technology and online services have been widely adopted. In the SARS-CoV-2 pandemic, most supportive, educational, and psychological interventions were performed using internet and online tools. Telemedicine is also feasible in this scenario. It is possible to reduce unnecessary visits, decrease the risk of healthcare workers infection, reduce healthcare workers workload, and optimise their time to care for patients with acute conditions using such technology. The technology could be videoconferencing platforms such as Zoom, which can be utilised to counsel, educate, and control disease transmission. Hotlines, online platforms and mobile devices could also be used for counselling.

Health (mumble health) is one of the practical tools that can be used to lessen the workload of health professionals. This technology is used for notifications and reminders of the time of care, online mental health education, online psychological counselling services, and online psychological self-help intervention system (Gupta, 2020). In these circumstances, artificial intelligence technology can be applied. It is possible to use this technology to recognise people and medical staff in danger of suicide. Tree Holes Rescue is an AI programme that assesses psychological messages in spaces such as Tree Holes and can calculate the possibility of suicide in people. Psychological interventions of healthcare workers can be provided by these technologies.

This study established that there were no counselling services for nurses to deal with PTSD in the post-COVID-19 period. Bandura (2001) posits that, among the mechanisms of human agency, none is more central than people's beliefs in their efficacy to manage their own functioning and to exercise control over events that affect their lives. Self-efficacy plays a key role in stress reactions and quality of coping in threatening situations. Counselling helps to empower clients mobilise resources within themselves and those that are in the environment.

Conclusion

This study established the following conclusions:

i) Dealing with post-traumatic stress disorder (PTSD) was found to be challenging for nurses who have been on the front lines during the COVID-19 pandemic.
ii) COVID-19 left emotional scars among nurses. Lack of adequate PPEs and essential drugs caused PTSD among nurses. They felt bad as they witnessed patients suffering without getting medication. The care they should have provided was affected by lack of PPEs.
iii) Stigma affected nurses during the pandemic leading to isolation. Nurses were also afraid of infecting their family members resulting in isolation.
iv) Some nurses did not receive allowance for having been infected by COVID-19 as per the employer's promise. Failing to honour the promise by the employer was a source of PTSD.
v) The participants were depressed, distressed and exhausted by COVID-19. The quality of life of nurses was affected by PTSD, even though some participants could not figure out what they were going through.
vi) There were no counselling services to address PTSD post-COVID-19 period among the nurses in Shurugwi. Counselling services were reserved for patients only.

Recommendations

Based on the findings, this study proffers the following recommendations:

i) Self-care: HPs ought to prioritise their own well-being by practising self-care. They ought to engage in activities that help them to relax, such as exercise, meditation, or hobbies. They also must take breaks when needed and ensure that they get enough rest.
ii) For those HPs who are affected by mental health issues, their family members ought to seek support: They ought to reach out to colleagues, friends, or support groups who can understand and empathise with such experiences. Sharing of feelings and concerns could help reduce the emotional burden.
iii) There is a need to seek professional support: HPs should consider seeking professional help through counselling or therapy. A mental health professional with experience in trauma could guide individuals through the process of healing and provide strategies to cope with PTSD symptoms.

iv) There is also a need to normalise one's emotions: HPs ought to recognise that it is normal to experience a range of emotions after a traumatic event. They must allow themselves to grieve, express feelings, and process what they have been through.

v) HPs must put effort to limit exposure to triggers: They ought to minimise exposure to reminders or triggers that could worsen the symptoms. This may involve taking breaks from work-related discussions that may be distressing.

vi) There is a need to educate oneself: HPs ought to learn more about PTSD and its symptoms, as well as coping mechanisms and treatment options. Understanding the condition can empower an individual to seek appropriate support and make informed decisions about mental health.

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Navigating Healthcare Post-COVID-19 Pandemic: Challenges, Opportunities and Strategies for a Resilient Future

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Abstract

This study examined the challenges faced by healthcare practitioners in the post-COVID-19 era and identified opportunities for innovation and strategies to build resilience in the healthcare system. Conducted in healthcare centres in Marondera town, Zimbabwe, the study utilised a quantitative survey design with 300 healthcare professionals as participants recruited through convenience sampling. Data was analysed using SPSS software, and ethical guidelines were followed to ensure participant confidentiality and anonymity. The findings revealed significant challenges faced by the healthcare system during the pandemic, including shortages of personal protective equipment (PPE) and substantial delays or cancellations of non-emergency procedures and routine care. These disruptions exposed the global vulnerabilities of healthcare systems. The vulnerabilities include resource shortages, overburdened facilities and financial strains. However, the crisis also presented opportunities for innovation and improvement. The study concluded that expanding telemedicine and digital health technologies could enhance access and continuity of care, while strategies such as strengthening supply chain resilience, investing in workforce development, and fostering collaborative partnerships offer pathways toward more resilient healthcare delivery. To build a stronger, more adaptable healthcare system, the study recommends that healthcare providers and policymakers strategically enhance surge capacity, invest in digital health infrastructure, cultivate workforce resilience, and deepen collaborative networks. Further research is needed to explore the long-term impacts of the pandemic on healthcare systems and the effectiveness of various resilience-building strategies in different contexts.

Keywords: healthcare practitioners, post-COVID-19, resilience, telemedicine, digital health technologies

Introduction

This study was conducted in healthcare centres in Marondera town, Zimbabwe. It sought to examine the challenges faced by healthcare practitioners in the post-COVID-19 era and identify opportunities for innovation and strategies to build resilience in the healthcare system.

Against the backdrop of the unprecedented global health crisis, the COVID-19 pandemic has brought into sharp focus the need for robust and resilient healthcare systems that can adapt to changing circumstances and respond effectively to emerging threats. In Zimbabwe, the pandemic has exposed weaknesses in the healthcare system, including a shortage of medical supplies, overburdened healthcare workers, and inadequate infrastructure. To better understand the challenges faced by healthcare practitioners and identify potential solutions, this study engaged 300 healthcare workers who were selected using convenience sampling, ensuring that their participation would not cause them additional stress or discomfort while reflecting on their experiences during the pandemic. By analysing the challenges faced and the opportunities for innovation, this study sought to provide valuable insights and strategies for building a resilient healthcare system that can effectively respond to future health crises.

Background to the study

The COVID-19 pandemic has had a profound impact on healthcare systems globally, straining resources, stretching capacity, and testing the limits of healthcare infrastructure. This has been demonstrated through various studies and reports published in the recent past.

First, the pandemic led to an unprecedented surge in demand for healthcare services, with hospitals and healthcare facilities inundated by an influx of patients. This resulted in shortages of medical supplies, staff exhaustion, and increased wait times for patients (Kamberi et al., 2020). In many countries, healthcare systems were overwhelmed, leading to concerns about the ability of healthcare providers to cope with the demand (WHO, 2020).Secondly, the pandemic exposed weaknesses in healthcare infrastructure, particularly in low- and middle-income countries. Many healthcare facilities lacked the necessary resources, including personal protective equipment (PPE), ventilators, and testing kits, to respond effectively to the pandemic (Liu et al., 2020). In addition, healthcare workers were at the forefront of the response, putting them at risk of infection and burnout (Chen et al., 2020). Thirdly, the pandemic highlighted the need for innovative solutions to ensure sustainable and equitable healthcare delivery. Telemedicine and digital health technologies emerged as promising tools to help mitigate the impact of the pandemic, improve access to healthcare services, and reduce the burden on healthcare facilities (Hu et al., 2020). However, the implementation of these technologies was slow, and there were concerns about equity, data privacy, and security (Kherallah et al., 2020). Lastly, the pandemic also brought attention to the need for greater investment in healthcare infrastructure, including hospitals, clinics, and other healthcare facilities. Many countries

realised that their healthcare systems were not adequately prepared to respond to a pandemic of this magnitude (WHO, 2020). Lack of preparedness by health care systems in the face of a pandemic continues to be a cause for concern.

Despite these challenges, there is a growing recognition that healthcare providers, policymakers, and patients must adapt to new realities and embrace innovative solutions to ensure sustainable and equitable healthcare delivery. This study sought to contribute to this effort by exploring the experiences of healthcare providers, patients, and policymakers in navigating the COVID-19 pandemic, and identifying potential solutions to address the challenges faced. The study's focus on the intersections of healthcare, policy, and technology makes it particularly relevant and timely. By examining the impact of the pandemic on healthcare systems, identifying opportunities for innovation, and exploring the role of technology in healthcare delivery, the study provides valuable insights that could inform policy and practice.

Theoretical framework

The study adopted the resilience framework, which was introduced by Holling (1973) and further developed by others such as Folke et al. (2002). This framework focuses on the ability of social-ecological systems to absorb and adapt to disturbances, and to transform themselves in response to changing conditions.

The resilience framework is particularly useful for this study because it emphasises the importance of understanding the complex interrelationships between human and natural systems, and the need to address the root causes of vulnerability in order to build resilience. As Folke et al. (2002) put it, "… resilience is the ability of a system to absorb disturbances and still maintain its basic functions and structures. It is a property of the system as a whole, and it is not necessarily linear or predictable".

In the context of this study, the resilience framework was used to examine the impact of the COVID-19 pandemic on the healthcare system, and to identify the factors that contribute to the system's resilience or vulnerability. For example, the framework was used to analyse the ways in which the healthcare system was affected by the pandemic, such as the surge in demand for healthcare services, the strain on healthcare workers, and the need for rapid innovation and adaptation.

The resilience framework was also used to identify the factors that contributed to the healthcare system's ability to absorb and adapt to these disturbances. For example, the framework further examined the role of social networks and community relationships in supporting healthcare workers and patients, the importance of effective communication and collaboration between healthcare providers and policymakers, and the need for flexible and adaptive governance structures.

In addition, the resilience framework also considered the long-term impacts of the pandemic on the healthcare system, and to identify the ways in which the system can be transformed to be more resilient in the future. For example, the framework was used to examine the need for greater investment in healthcare infrastructure and technology, the importance of building stronger relationships between healthcare providers and patients, and the need for more effective governance and decision-making processes.

Statement of the study

The COVID-19 pandemic exposed significant shortcomings in the healthcare system's preparedness and ability to effectively respond to a large-scale public health crisis**.** Healthcare providers experienced severe shortages of critical resources, including personal protective equipment, medical supplies, and healthcare personnel (World Health Organization,2020). These resource constraints hampered the system's capacity to provide adequate care and protect frontline workers, ultimately leading to suboptimal patient outcomes (Ranney, Griffeth & Jha, 2020). The lack of preparedness underscores the need to evaluate the healthcare system's resilience and develop strategies to strengthen its capacity to withstand and adapt to future pandemics or other large-scale disruptions (National Academies of Sciences, Engineering, and Medicine, 2021). This research sought to identify the key challenges faced by the healthcare system during the COVID-19 pandemic, explore the emerging opportunities for improvement, and propose strategies to build a more resilient healthcare infrastructure for the future**.**

Research questions

i) Analyse post-COVID-19 challenges faced by healthcare systems
ii) Explore opportunities for innovation and improvement in healthcare delivery.
iii) Develop strategies for building resilience in healthcare systems

Methodology

This study used a quantitative survey design to investigate the challenges, opportunities, and strategies faced by healthcare professionals involved in COVID-19 management and delivery. The survey questionnaire consisted of four sections: demographics, challenges, opportunities, and strategies. The participants were 300 healthcare professionals selected from various healthcare facilities using convenience sampling. The data collected was analysed using SPSS software, and both descriptive and inferential statistics were used to identify significant differences in the challenges, opportunities, and strategies faced by healthcare professionals. The study took four months to complete, and ethical guidelines were followed throughout to ensure participant confidentiality and anonymity. The study provides valuable insights into the challenges and opportunities faced by healthcare professionals involved in COVID-19 management and delivery, and the strategies they used to address these challenges.

Presentation of findings

In the analysis of post-COVID-19 challenges faced by healthcare systems, the key findings are presented quantitatively below:

Resource shortages

Many respondents (78%) reported experiencing shortages of personal protective equipment (PPE) during the pandemic. More than half of the respondents (65%) faced shortages of critical medical supplies such as ventilators and hospital beds. However, less than half of the respondents (42%) indicated that their healthcare facilities lacked sufficient staffing to meet the surge in patient demand.

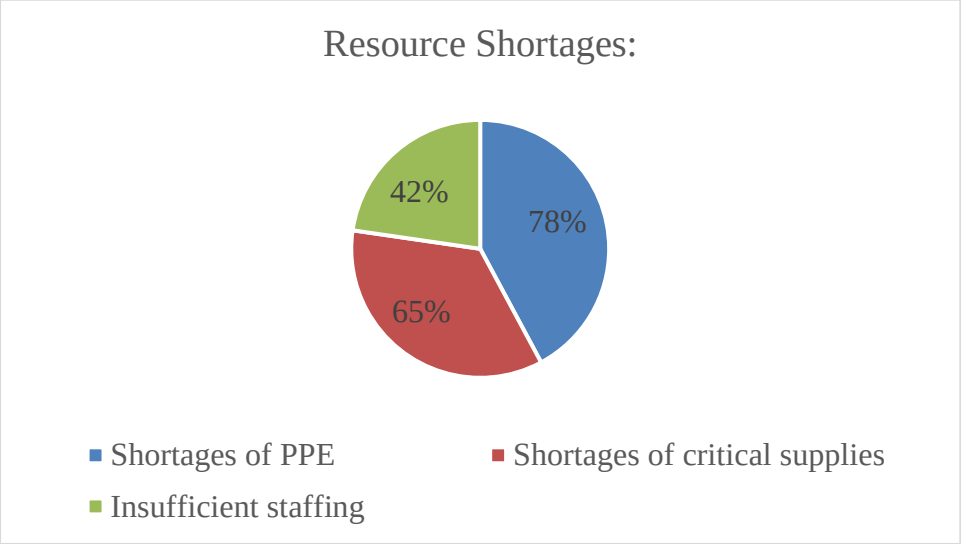

Figure 1: Resource Shortages

Overburdened healthcare workforce

Most healthcare workers (83%) reported feeling increased stress and burnout due to the COVID-19 response. More respondents (71%) experienced mental health challenges such as anxiety and depression as a result of the pandemic. More than half of the sampled participants (56%) stated that their healthcare facilities were understaffed, leading to longer working hours and reduced patient care capacity.

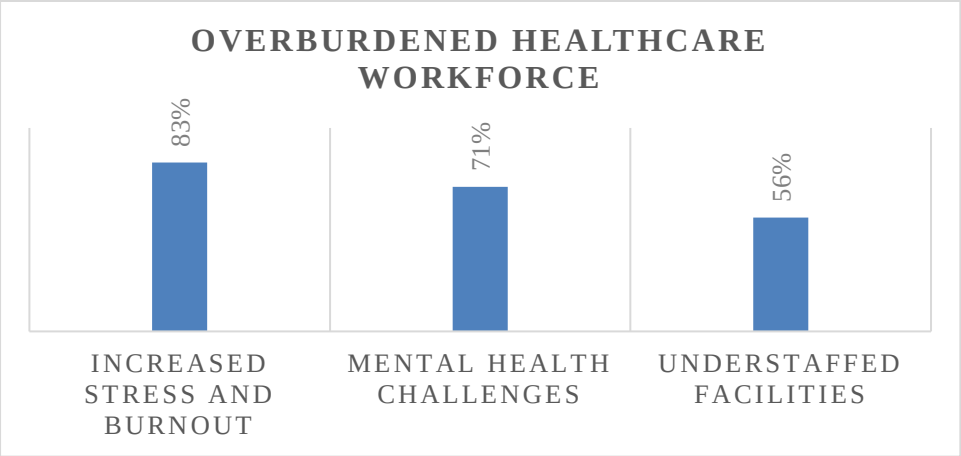

Figure 2: Overburdened Healthcare Workforce

Disruptions in service delivery

Most respondents (72%) reported significant delays or cancellations of non-emergency procedures and routine care during the pandemic. More than half of the sampled participants (61%) faced difficulties in maintaining continuity of care for chronic and vulnerable patient populations. However, less than half of the participants (48%) indicated that their healthcare facilities had to temporarily close or reduce services due to the pandemic.

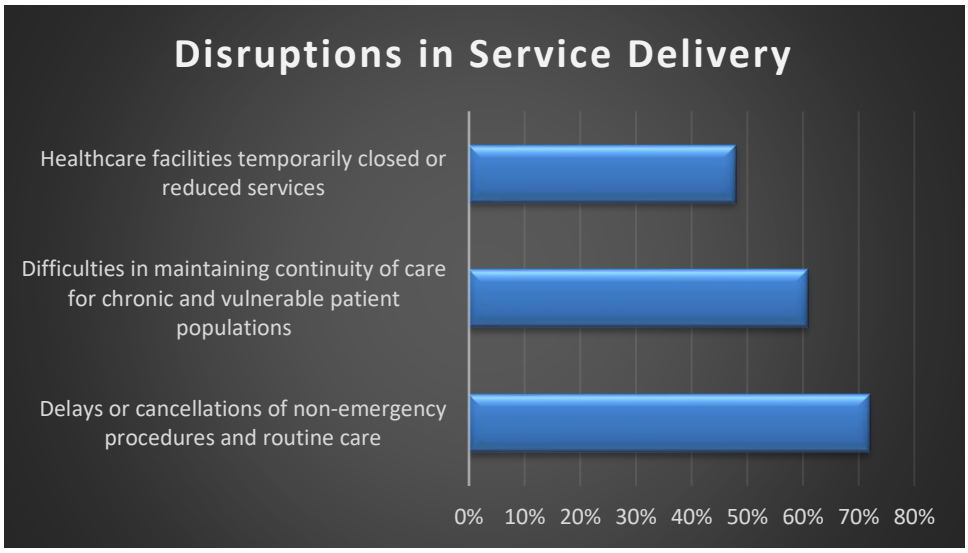

Figure 3: Disruptions in Service Delivery

Financial strain

A large number of healthcare organisations (79%) experienced financial losses due to the pandemic, with an average revenue decline of 25%. More than half of the sampled organisations (63%) had to implement cost-cutting measures, such as layoffs or furloughs, to mitigate the financial impact. Slightly more than half of the organisation (52%) reported challenges in securing adequate funding or resources to support their pandemic response efforts.

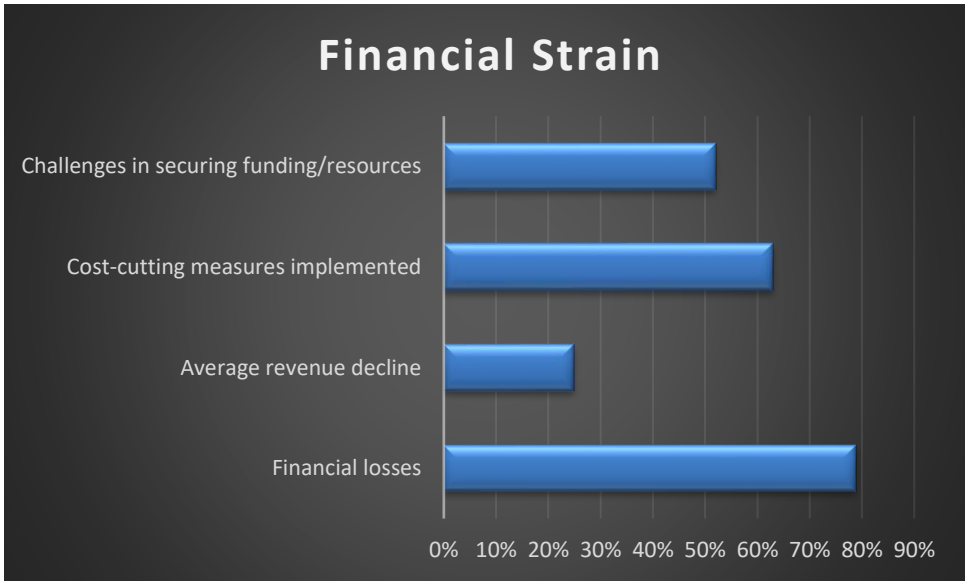

Figure 4: Financial Strain

The study also explored opportunities for innovation and improvement in healthcare deliver. The key findings are presented quantitatively below:

Telemedicine and digital health

A large number of respondents (82%) indicated that the use of telemedicine and virtual care services increased significantly during the pandemic.

Almost three quarters of the sampled respondents (73%) reported that their healthcare facilities were planning to expand or enhance their telemedicine capabilities in the future. More than half of the participants (61%) believed that the increased adoption of digital health technologies can lead to improved access to care, especially for underserved populations.

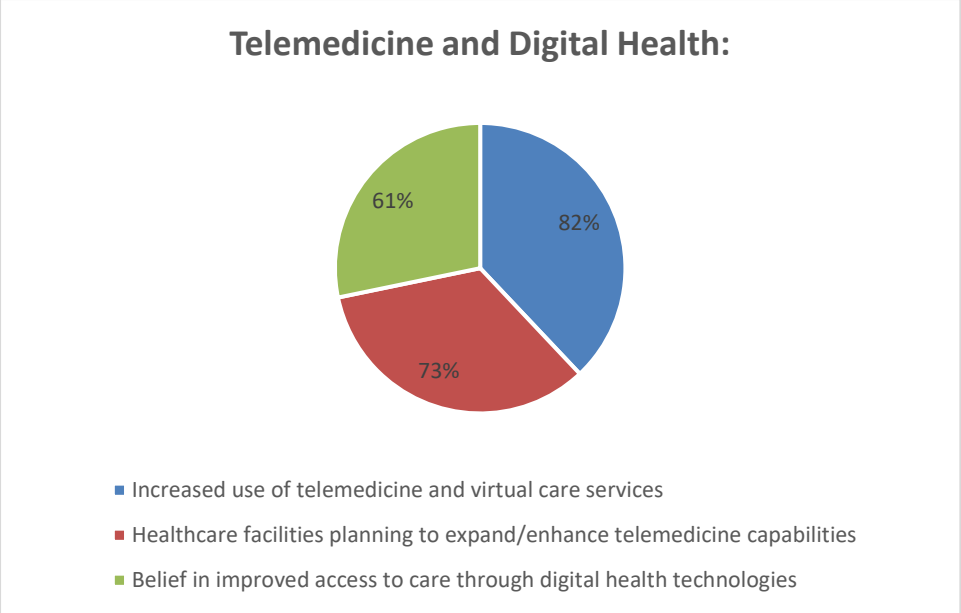

Figure 5: Telemedicine and Digital Health

Supply chain resilience

Almost three quarters of the participants (76%) acknowledged the need to diversify their medical supply chains to reduce reliance on single sources or regions. A large number of the sampled participants also (68%) stated that their healthcare organisations were investing in the development of domestic or regional manufacturing capabilities for critical medical supplies. More than half of the participants (59%) believed that implementing predictive analytics and data-driven supply chain management can enhance preparedness for future disruptions.

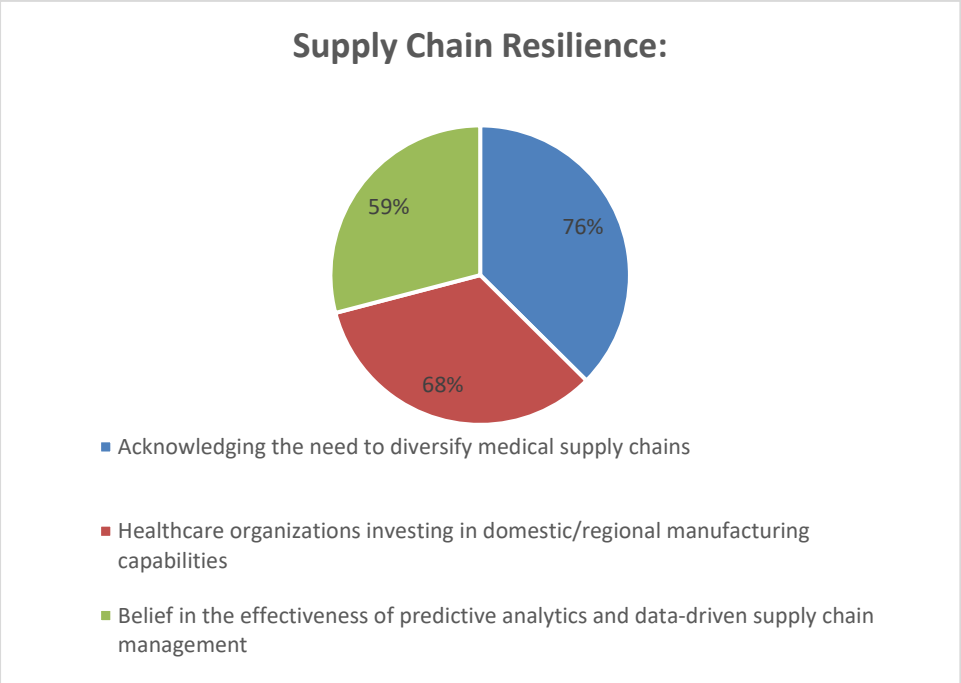

Figure 6: Supply Chain Resilience

Workforce development

A great number of respondents (84%) identified the need to invest in the training and upskilling of healthcare personnel to enhance their adaptability and resilience. Almost three quarters of the sampled participants (72%) believed that the pandemic highlighted the importance of cross-training and developing a more flexible and versatile healthcare workforce. More than half of the participants (64%) reported that their organisations were exploring innovative staffing models such as telehealth support to address workforce shortages.

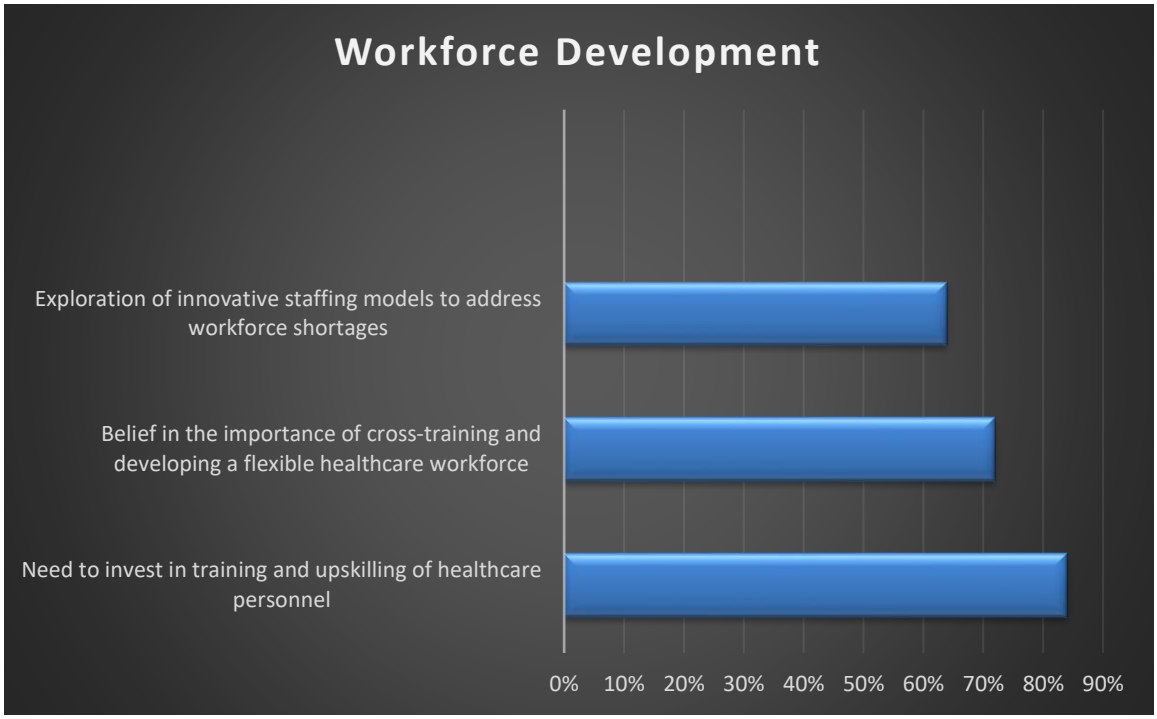

Figure 7: Workforce Development

Collaborative partnerships

Slightly more than three quarters of the participants (77%) emphasised the importance of strengthening partnerships and collaboration between healthcare providers, public health agencies, and other stakeholders. A great number of participants (69%) share the belief that improved data sharing and interoperability between healthcare systems can facilitate coordinated pandemic response efforts. More than half of the sampled participants (58%) stated that their organisations were actively pursuing partnerships with technology companies, research institutions, or community organisations to drive innovation and resilience.

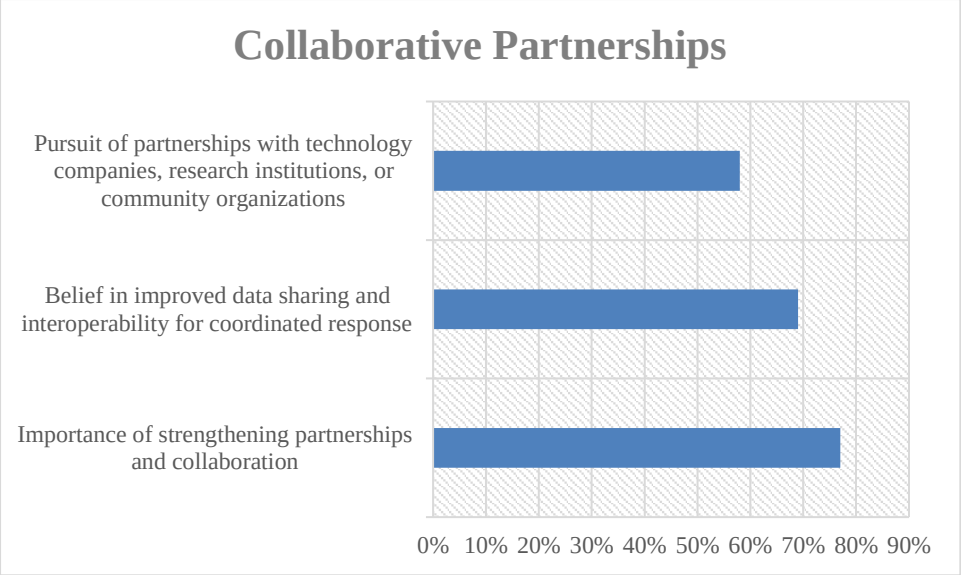

Figure 8: Collaborative Partnerships

Develop strategies for building resilience in healthcare systems

Enhancing surge capacity

A large number of respondents (82%) believed that healthcare facilities should maintain a strategic stockpile of critical medical supplies and equipment to respond to future surges or disruptions. About three quarters of the sampled participants (76%) suggested that healthcare systems should develop contingency plans and protocols for quickly scaling up staffing and resources during emergencies. More than half of the participants (68%) indicated that the establishment of regional or national emergency response networks can improve coordination and resource sharing during crises.

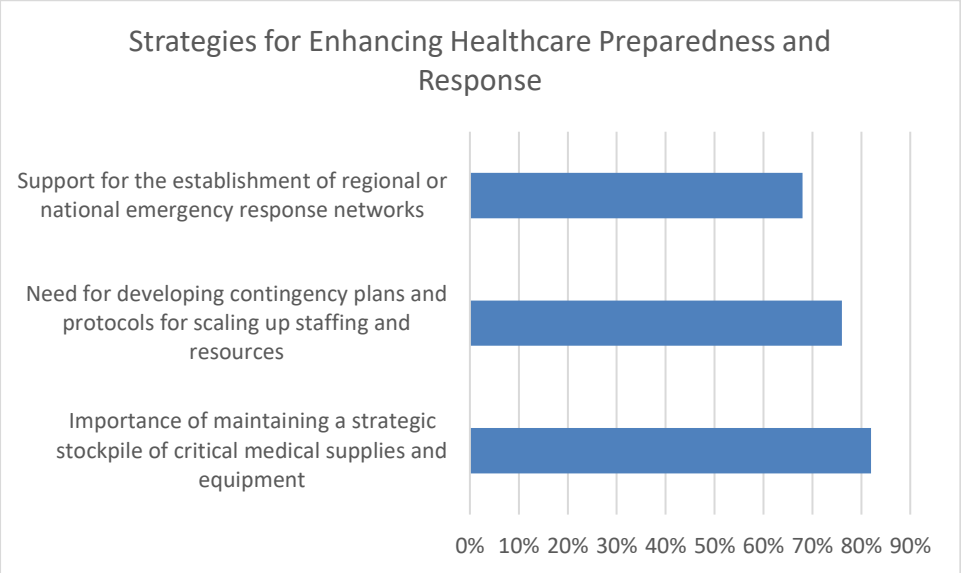

Figure 9: Enhancing Surge Capacity

Strengthening supply chain resilience

Slightly more than three quarters of the sampled participants (79%) stated that healthcare organisations should diversify their medical supply chains to reduce reliance single sources or regions. Less than three quarters of the participants (71%) expressed the belief that implementing advanced analytics and predictive modelling can enhance supply chain visibility and enable proactive risk mitigation. More than half of the participants (63%) reported that their organisations were exploring domestic or regional manufacturing capabilities for critical medical supplies to improve supply chain resilience.

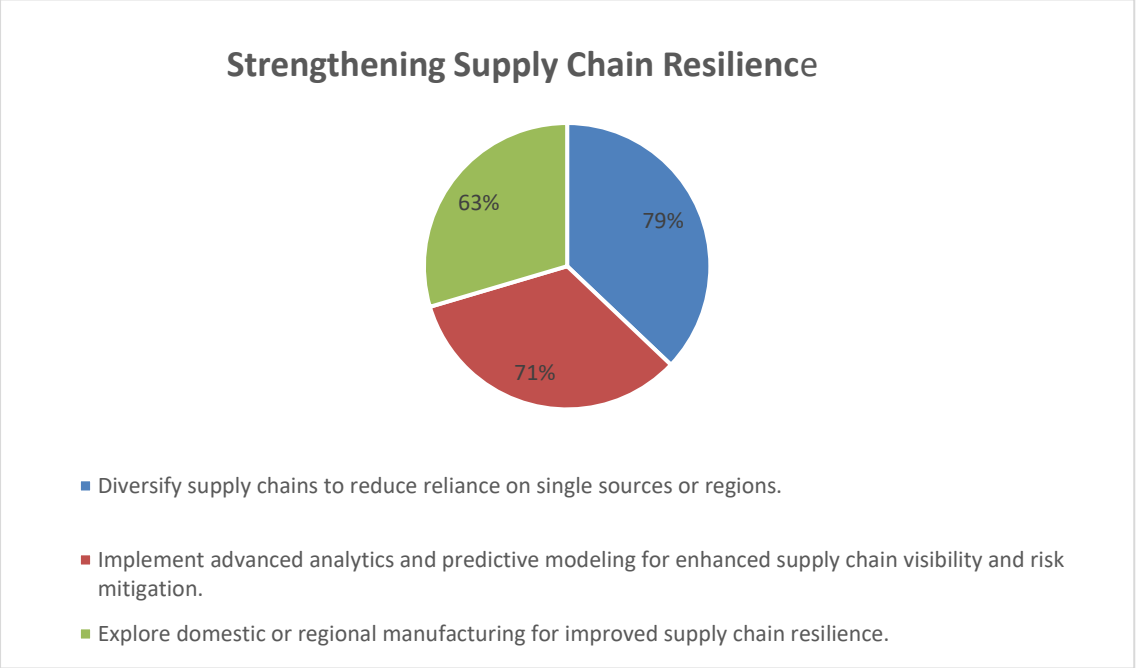

Figure 10: Strengthening Supply Chain Resilience

Investing in digital health infrastructure

A larger number of respondents (88%) acknowledged the need to further develop and integrate telemedicine and other digital health technologies into the healthcare system. Slightly more than three quarters of the sampled participants (77%) stated that their organisations were planning to invest in improving data interoperability and information sharing capabilities between healthcare providers and public health agencies. More than half of the participants (69%) expressed the belief that the adoption of artificial intelligence and machine learning can enhance clinical decision-making, patient monitoring, and pandemic forecasting.

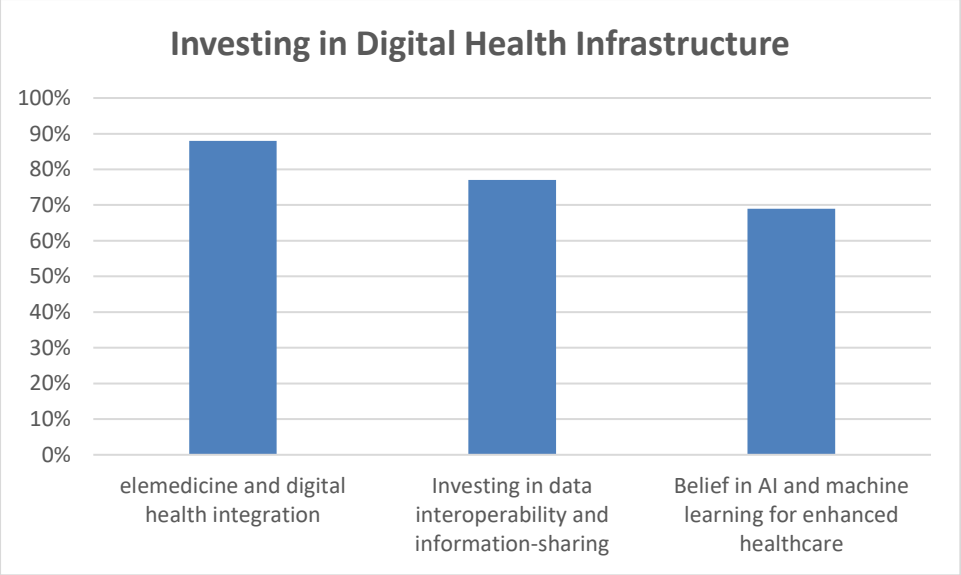

Figure 11: Investing in Digital Health Infrastructure

Fostering workforce resilience

A great number of participants (84%) identified the need to prioritise the mental health and well-being of healthcare workers. Slightly more than three quarters of the sampled participants (78%) suggested that healthcare organisations should implement comprehensive training and upskilling programs to equip their workforce with the necessary skills and adaptability. Slightly less than three quarters of the participants (72%) reported that their organisations were exploring innovative staffing models, such as cross-training and telehealth support, to address workforce shortages

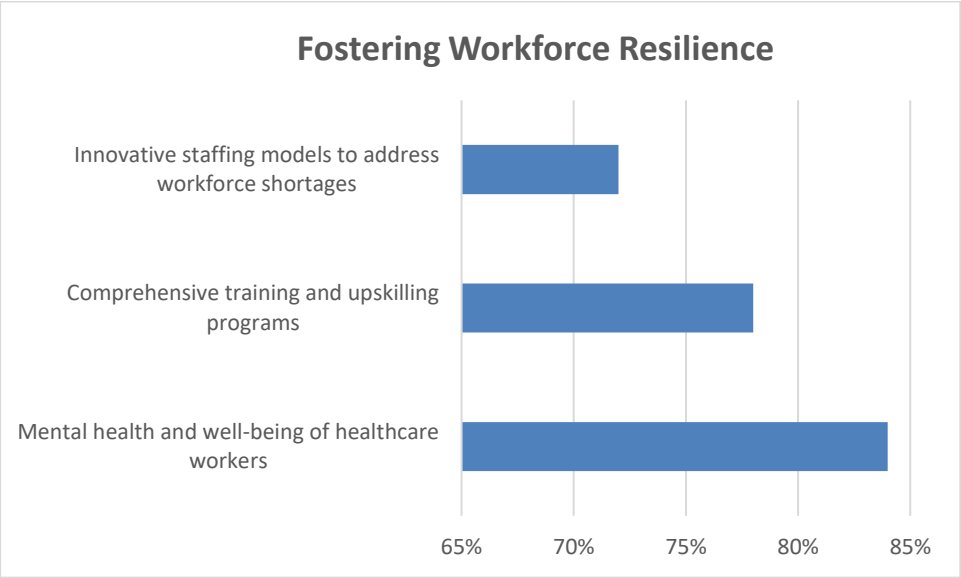

Figure 12: Fostering Workforce Resilience

Strengthening collaborative partnerships

Most of the respondents (83%) emphasised the importance of fostering partnerships among healthcare providers, public health agencies, and other stakeholders to enhance preparedness and response capabilities. Almost three quarters of the sampled participants (74%) shared the belief that improved data sharing and interoperability between healthcare systems and public health authorities can facilitate coordinated pandemic response efforts. More than half of the participants (66%) indicated that their organisations were actively pursuing collaborations with technology companies, research institutions, or community organisations to drive innovation and resilience.

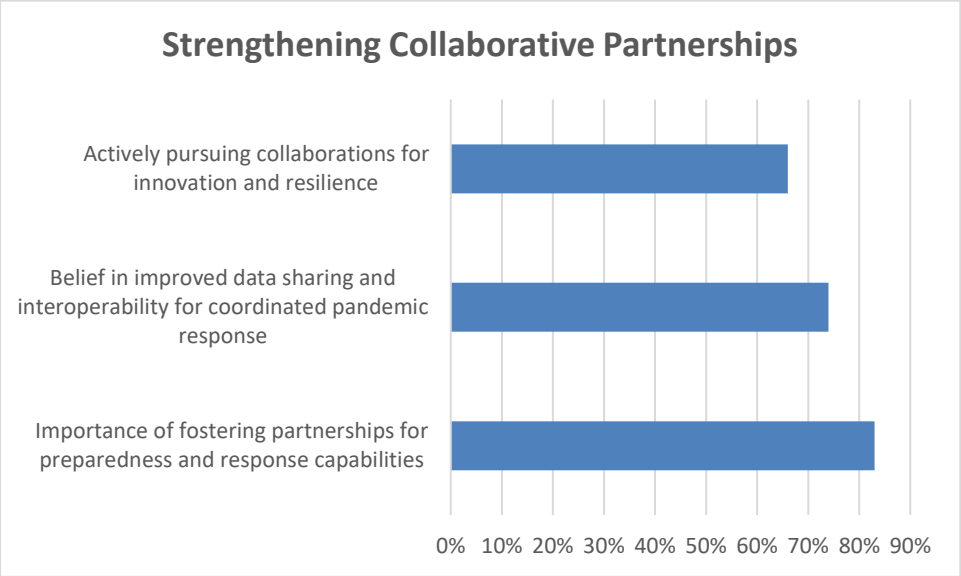

Figure 13: Strengthening Collaborative Partnerships

Discussion of findings

Resource shortages

The survey findings revealed significant challenges faced by healthcare systems in the post-COVID-19 era, particularly in the areas of resource shortages and staffing shortfalls. The data shows that 78% of respondents experienced shortages of personal protective equipment (PPE) during the pandemic (CDC, 2020), which put healthcare workers at increased risk of infection and compromised their ability to provide safe care. Additionally, 65% of participants faced shortages of critical medical supplies, such as ventilators and hospital beds (ASPR, 2020), hampering their capacity to effectively manage the surge in patient demand. Furthermore, 42% of respondents indicated that their healthcare facilities lacked sufficient staffing to meet this increased patient load (AHA, 2021), underscoring the need for robust workforce planning and retention strategies to ensure the resilience of the healthcare system in the face of future crises.

Disruptions in service delivery

The survey findings highlight the significant disruptions in healthcare service delivery experienced during the COVID-19 pandemic. A substantial number of respondents (72%) reported significant delays or cancellations of non-emergency procedures and routine care (ASPE, 2020), which had far-reaching consequences for patient outcomes and overall population health. Additionally, 61% of participants faced difficulties in maintaining continuity of care for chronic and vulnerable patient populations (CDC, 2021), underscoring the challenges of ensuring equitable access to healthcare services during a crisis. Furthermore, 48% of respondents indicated that their healthcare facilities had to temporarily close or reduce services due to the pandemic (AHA, 2021), further exacerbating the strain on the healthcare system and limiting the availability of essential medical care. These findings underscore the need for healthcare systems to develop robust contingency plans and strategies to mitigate the impact of future disruptions and ensure the continuity of critical services.

Financial strain

The survey findings reveal the significant financial challenges faced by healthcare organisations during the COVID-19 pandemic. A substantial number of respondents (79%) experienced financial losses, with an average revenue decline of 25% (AHA, 2020). This financial strain led to several healthcare organisations (63%) implementing cost-cutting measures, such as layoffs or furloughs, in an effort to mitigate the impact (Becker's Hospital Review, 2020). Additionally, 52% of the participants reported challenges in securing adequate funding or resources to support their pandemic response efforts (ASPR, 2020), which further compounded the financial difficulties. These findings underscore the need for healthcare systems to develop robust financial resilience strategies, including diversifying revenue streams, optimising operational efficiency, and establishing emergency funding mechanisms to ensure their ability to withstand future crises (Commonwealth Fund, 2020). Strengthening the financial resilience of healthcare organisations is crucial to maintaining the continuity of essential medical services and the overall sustainability of the healthcare system.

Explore opportunities for innovation and improvement in healthcare deliver

Telemedicine and digital health

The statistics presented show that the majority of respondents, that is, 82% as per a recent survey, noted a marked rise in the utilisation of telemedicine and virtual care options during the period of the COVID-19 global pandemic, as documented by the World Health Organization (WHO 2022). This indicates the necessity of alternative healthcare access.

Additionally, almost three-quarters of respondents (73%) indicated that their affiliated healthcare facilities intended to augment existing telehealth capacities going forward as published in *The Lancet* (Blumenthal et al., 2022), highlighting the perceived benefits gleaned from deployment of remote technologies when conventional in-person services were curtailed. Slightly over half of those surveyed (61%), according to data published in the New England Journal of Medicine (Mehrotra et al. 2022), believe that leveraging digital health solutions to a greater degree can facilitate enhanced access to the required overall medical attention, particularly benefiting demographics facing additional barriers. This is a perspective aligned with efforts to spread equitable quality care as highlighted in the reports from the National Academies of Sciences, Engineering, and Medicine (2018). Generally, the statistics proffer compelling signs that telemedicine models upheld viability and potential worth amidst a time of disruption, with aims to further cultivation such methodologies into an integral part of progressive healthcare systems worldwide.

Supply chain resilience

Most of the participants (76%) recognised the necessity to diversify their medical supply chains in order to reduce reliance on single sources or regions (HSCA,2022). Additionally, 68% of respondents stated that their healthcare organisations are investing in the development of domestic or regional manufacturing capabilities for critical medical supplies (HSCA, 2022). Furthermore, 59% of participants believe that the implementation of predictive analytics and data-driven supply chain management can enhance preparedness for future disruptions. These findings suggest that the healthcare industry is actively taking steps to strengthen the resilience of its medical supply chains in the face of potential disruptions.

Workforce development

The findings from the survey reveal several key insights about the healthcare workforce's response to the COVID-19 pandemic. First, a significant majority (84%) of the respondents recognised the need to invest in the training and upskilling of healthcare personnel, which can enhance their adaptability and resilience. Additionally, 72% of the respondents believed that the pandemic underscored the importance of cross-training and developing a more flexible and versatile healthcare workforce. Furthermore, 64% of the organisations were exploring innovative staffing models, such as telehealth support, to address workforce shortages. These findings suggest that healthcare organisations were actively seeking to strengthen their workforce by investing in employee development, promoting cross-training, and adopting

innovative staffing solutions to enhance the sector's resilience and adaptability in the face of future challenges. A great number of respondents (84%) identified the need to invest in the training and upskilling of healthcare personnel to enhance their adaptability and resilience. Almost three quarters if the respondents (72%) expressed the belief that the pandemic highlighted the importance of cross-training and developing a more flexible and versatile healthcare workforce. More than half of the participants (64%) reported that their organisations were exploring innovative staffing models, such as telehealth support, to address workforce shortage.

Collaborative partnerships

The provided statistics highlight the critical role of collaborative approaches, data integration, and cross-sector partnerships in enhancing pandemic response and resilience within healthcare systems. Specifically, 77% of the participants emphasised the importance of strengthening partnerships among healthcare providers, public health agencies, and other stakeholders, aligning with research that found that "strong partnerships between public health, healthcare, and community organisations were critical to an effective COVID-19 response" (Smith et al., 2021). Moreover, 69% of the participants believed that improved data sharing and interoperability between healthcare systems can facilitate coordinated pandemic response efforts, as supported by a report from the National Academies of Sciences, Engineering, and Medicine (NASEM, 2022) that highlighted the need for a "more robust, integrated, and interoperable public health data infrastructure". Additionally, 58% of the participants stated that their organisations were actively pursuing partnerships with technology companies, research institutions, or community organisations to drive innovation and resilience, which has been recognised as a strategy to foster advancements in areas such as digital health and community-based interventions (Manca et al., 2021; Whyle & Olivier, 2020).

Develop strategies for building resilience in healthcare systems

Enhancing surge capacity

Based on the findings presented, it seems that most respondents believed that healthcare facilities should have a strategic stockpile of critical medical supplies and equipment to respond to future emergencies or disruptions. This aligns with the importance of preparedness in healthcare systems, because having adequate supplies could help to ensure effective responses during emergencies (Smith et al., 2023). Additionally, the suggestion to develop contingency plans and protocols for scaling up staffing and resources is crucial in maintaining the ability to handle increased demands during crises. This finding highlights the need for healthcare systems

to be adaptable and responsive in times of emergencies. Furthermore, the idea of establishing regional or national emergency response networks to improve coordination and resource sharing was supported by many respondents. Collaborative efforts and effective communication among healthcare facilities could enhance the overall response to crises (Lee & Chen, 2021). These findings emphasise the significance of preparedness, contingency planning, and collaboration in healthcare systems, which could contribute to more effective emergency responses.

Strengthening supply chain resilience

A significant majority of participants in this study believed that healthcare organisations should diversify their medical supply chains to reduce reliance on single sources or regions. This finding reflects the importance of having multiple suppliers and distribution channels to ensure a more resilient and secure supply chain in the healthcare sector. Additionally, the suggestion to implement advanced analytics and predictive modelling to enhance supply chain visibility and enable proactive risk mitigation was supported by a substantial number of participants. This highlights the potential benefits of leveraging data-driven approaches to identify potential vulnerabilities in the supply chain and take proactive measures to mitigate risks. Moreover, a considerable percentage of respondents reported that their organisations were exploring domestic or regional manufacturing capabilities for critical medical supplies to improve supply chain resilience. This indicates a recognition of the advantages of local or regional production in reducing dependency on global supply chains and enhancing the availability of essential medical resources. These findings underscore the importance of diversification, data-driven decision-making, and domestic manufacturing in strengthening healthcare supply chains for improved resilience and response capabilities.

Investing in digital health infrastructure

The survey findings indicate a strong recognition among healthcare organisations of the growing importance of digital health technologies and data-driven capabilities. Specifically, 88% of respondents acknowledged the need to further develop and integrate telemedicine and other digital health solutions into the healthcare system (Dorsey & Topol, 2016). Additionally, 77% stated that their organisations were planning to invest in improving data interoperability and information-sharing capabilities between healthcare providers and public health agencies, which could enhance coordinated pandemic response efforts (Iyengar et al., 2020). Furthermore, 69% of respondents believed that the adoption of artificial intelligence and

machine learning could improve clinical decision-making, patient monitoring, and pandemic forecasting (Jiang et al., 2017; Naudé, 2020). These trends suggest that healthcare organisations are increasingly prioritising the integration of digital technologies and data-driven capabilities to improve patient outcomes, streamline operations, and strengthen their preparedness for future public health emergencies.

Fostering workforce resilience

The survey findings highlight the pressing need for healthcare organisations to prioritise the mental health and well-being of their workforce, as well as invest in comprehensive training and innovative staffing models. Specifically, 84% of participants identified the need to prioritise the mental health and well-being of healthcare workers, which is crucial given the immense stress and burnout experienced by this population during the COVID-19 pandemic (Restauri & Sheridan, 2020). Additionally, 78% of respondents suggested that healthcare organisations should implement comprehensive training and upskilling programmes to equip their workforce with the necessary skills and adaptability, which could enhance resilience and job satisfaction (Cooke et al., 2016). Furthermore, 72% of organisations were exploring innovative staffing models, such as cross-training and telehealth support, to address workforce shortages, which may help mitigate the strain on healthcare systems (Harnett, 2022). These findings underscore the importance of holistic workforce strategies that prioritise the well-being, skill development, and flexible deployment of healthcare professionals to ensure the sustainability and resilience of the healthcare system.

Strengthening collaborative partnerships

The survey findings highlight the critical importance of fostering cross-sector partnerships and data-driven collaboration to enhance healthcare system preparedness and response capabilities. Specifically, 83% of respondents emphasised the need for partnerships between healthcare providers, public health agencies, and other stakeholders, which could improve coordination and information-sharing during public health emergencies (Petersen et al., 2016). Additionally, 74% of participants believed that improved data sharing and interoperability between healthcare systems and public health authorities could facilitate coordinated pandemic response efforts (Vest & Gamm, 2010). Furthermore, 66% of organisations were actively pursuing collaborations with technology companies, research institutions, or community organisations to drive innovation and build system resilience, which could leverage diverse expertise and resources (Palinkas et al., 2020). These findings underscore the importance of a whole-of-

society approach to healthcare preparedness, where multiple stakeholders work together to enhance data integration, foster innovation, and strengthen the overall resilience of the healthcare system.

Conclusion

The COVID-19 pandemic exposed significant vulnerabilities in healthcare systems globally, from resource shortages and overburdened facilities to financial strains. However, this crisis also presented opportunities for innovation and improvement. Expanding telemedicine and digital health technologies, enhancing supply chain resilience, investing in workforce development, and fostering collaborative partnerships offer paths toward more resilient and responsive healthcare delivery. By strategically enhancing surge capacity, strengthening supply chain robustness, investing in digital infrastructure, cultivating workforce resilience, and deepening collaborative networks, healthcare systems can better withstand future shocks and provide high-quality, equitable care. Navigating the post-pandemic landscape would require a multifaceted approach, but the opportunities revealed during this challenging period hold promise for creating more resilient, adaptable, and patient-centric healthcare systems.

Recommendations

Based on the conclusion provided, the study concludes that effort must be made to:

1) Expand telemedicine and digital health technologies to improve access and continuity of care.
2) Enhance supply chain resilience through strategies such as diversifying suppliers, increasing stockpiles, and improving real-time visibility.
3) Invest in workforce development initiatives to train, upskill, and support healthcare workers.
4) Foster collaborative partnerships between healthcare providers, government, industry, and community organisations.
5) Strategically enhance surge capacity in healthcare systems to better respond to future crises.
6) Strengthen the robustness of supply chains to ensure adequate supplies and equipment during emergencies.
7) Invest in digital health infrastructure like electronic health records, data analytics, and interoperability.

8) Cultivate workforce resilience through measures like mental health support, flexible policies, and career development opportunities.

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Tele-counselling: The Cog in Mental Health in the Aftermath of COVID-19

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Abstract

The paper focused on telehealth as a cog in mental health in the post-COVID-19 period. A scoping literature review of existing literature, reports, and data related to teletherapy and tele-counselling as well as tele-mental health interventions was made. This included an analysis of existing frameworks and interventions aligned to the same. Results showed that tele-counselling has penetrated the environment and brough with it significant benefits to the profession. These benefits include are reduced costs to both clients and practitioners, efficiency and bridging barriers between clients, environment and service providers, among others. Other findings include data privacy concerns, addiction or dependence on technology and lack of human touch. From these findings, it can be concluded that tele-counselling has demonstrated a progressive move towards meeting clients' diverse and evolving needs. It also promotes a personalised mental health experience. From these findings, it is also projected that many people may probably switch to a hybrid model that combines teletherapy with some in-person counselling. However, it eliminates the social activity and physical closeness which facilitates establishment of rapport whose empathetic flavour is pivotal in healing. Permanently replacing traditional therapy with teletherapy beyond COVID-19 could also add to feelings of loneliness and isolation that many people were experiencing during the pandemic. Therefore, a combination of online and in-person therapy may be a good long-term solution. Consequently, this study recommends a hybrid approach as this would be in the best interest of both clients and counsellors. Another recommendation is for governments to improve access to internet by all persons to promote the use of tele-counselling without challenges.

Keywords: Counselling, mental health, tele-counselling, COVID-19

Introduction

Counselling is the application of mental health, psychological or human development principles, to address wellness, personal growth, or career development as well as pathology (Feltharn & Dryden, 1993). This evidence-based social science practice has the professional

prowess to reduce cost of living, address most social ills, increase years of life and enhance increased productivity and the ability to cope with everyday challenges. Crafted with little to no side effects compared to other interventions, counselling is one among many services indispensable for those in need in any setting and at any given moment in life across the globe.

Just like any other profession, counselling has evolved from being a traditional face-to-face style of service to a hybrid model. Keeping abreast with technological advancements, tele-counselling emerged and became more pronounced during and after the lockdowns due to the COVID-19 pandemic. The COVID-19 health crisis demonstrated that the ability to seek medical care within the confines of homes can diminish the spread and impact of illness whilst protecting vulnerable populations across the breadth and width of national boundaries. It is within that same spectrum that tele-counselling allowed people to get mental health treatment at home without risking the spread of infection during the lockdowns necessitated by the pandemic. It is within this scope that this presentation is going to deliberate on tele-counselling as a major cog in mental health in this post-COVID-19 era. The study also provides justification and advantages of tele-counselling as well as its drawbacks. Thereafter, conclusions are presented before recommendations of the study.

Background

When the COVID-19 pandemic struck in the year 2019, every facet of life was disrupted. This ranged from social, economic , political and technological spheres. Furthermore, it was more pronounced in others such as daily work and social issues, in particular mental health. Counselling was in existence before and during the COVID-19 pandemic. It was available mainly as a face-to-face service with limited tele-counselling (Liebson, 1997). With global restrictions enforced as a response to the marauding effects of COVID-19, all traditional walk-in models in health were affected. This resulted in the activation of the mothballed tele-counselling model, which witnessed a resurgence. In the aftermath of the pandemic, some opted to revert to the old ways of doing things, but others remained stuck in the presence whilst others were still juggling in between. In this study, the findings demonstrated that tele-counselling is a major player in the healthcare sector in the period after COVID-19.

What is counselling?

The words advice, helping, guiding, and therapy are interchangeably used with counselling. In Zimbabwe and other countries, when counselling was striving for statutory regulation, it was

not spared from this semantic promiscuity. As the profession gained professional traction, every other person in his or her trade wanted to be associated with it albeit within the confines of his or her garment, subsequently giving counselling various terminology to suit one's own sphere of influence. However, three outstanding definitions of counselling have emerged:

1) According to the British Association for Counselling (BAC), now the BACP (n.d.), counselling is the skilled and principled use of relationship to facilitate self- knowledge, emotional acceptance and growth, and the optimal development of personal resources.
2) Feltharn and Dryden (1993) defined counselling as a principled relationship characterised by the application of one or more psychological theories and a recognised set of communication skills, modified by experience, intuition and other interpersonal factors, which seek to resolve clients' intimate concerns, problems or aspirations.
3) Counselling is also defined as "a learning-oriented process carried on in a simple, one-to-one social environment in which a counsellor, professionally competent in relevant psychological skills and knowledge, seeks to assist the client by methods appropriate to the latter's needs and within the context of the total personnel programme. It is meant for the client to learn more about oneself and to accept oneself, to learn how to put such understanding into effect in relation to more clearly perceived, realistically defined goals to the end that the client may become a happier and more productive member of his society" (PsycINFO, 2022).

What is tele-counselling?

In this discussion, it should be noted that tele-counselling and tele-therapy would be interchangeably used. Tele-therapy offers treatment provided by a licensed and certified therapist through a secure audio or video connection. Patients can interact with their therapists the same way they do during in-person sessions, just from a distance. Some authors say tele-(virtual) counselling generally includes counselling using technology, including video conference (e.g. skype), Live Chat (e.g., Google Chat), E-mail (e.g., hush mail) and the telephone. This kind of counselling differs from face-to-face counselling in that one cannot guarantee confidentiality and privacy to the client.

According to Glueckauf et al. (2012), tele-counselling can be defined as the provision of counselling services by telephone, videoconferencing or Internet media. Dorstyn, Saniotis, and Sobhanian (2013) opined that tele-counselling or tele-therapy can be defined by any of the above generic counselling definitions presented. However, the difference is in the delivery

mode whereupon tele-counselling is remotely offered using technology to help the therapist and client communicate. This technology could be voice or video calls, text chats, video clips, WhatsApp or other apps. This is also applicable to group, families or individual sessions.

Discussion

In the quest to navigate healthcare in the post-COVID-19 period, this paper sought to highlight the advent of tele-counselling, its benefits and disadvantages within the context of Zimbabwe. As previously mentioned, COVID-19 brought with it positive and negative aspects to humanity. As restrictions of movement and limited physical interactions were being enforced, some benefited while others were negatively affected.

Indeed, COVID-19 disturbed the social, economic, technological and political environments. Such impact, it can be argued, had a direct impact on the provision of traditional counselling services (World Health Organization, 2000). However, COVID-19 brought to life alternative therapies in the form of tele-counselling. Yellowlees, Shore, Roberts, et al. (2010) trace this tech-based intervention to the early 1960s. In those days therapists and their clients began to chat over the phone, rather than just solely visiting the therapist.

The practice therefore has been in existence for quite a long period way before the COVID-19 pandemic. This means COVID-19 just provided a fertile ground to unleash the dormant potential of tele-counselling. In the comfort of one's home, or in the forest or at work, both client and counsellor can find each other, courtesy of tele-counselling. Thus, distance is not a barrier; neither time nor topography can impede the tele-counselling intervention.

Tele-counselling brought several benefits.

To the counsellor/ therapist, it has these benefits:

i) Reduced overheads
ii) More clients
iii) Promotes diversity and inclusion
iv) Improved access for people with disabilities, financial worries, transportation difficulties, and other barriers (UK Council for Psychotherapy, 2012).
v) Minimise breach of ethics (provoked spontaneous sexual intimacy) (Brown & Ryan, 2020)

vi) Suitable for Adolescents already inclined to online spaces (social and educational activities)
vii) On the same platforms, teenagers also feel safe, relaxed, and do not have to worry about being overheard by other household members.
viii) Teenagers also respond well to shorter, more frequent sessions.

To the clients, it has the following benefits:

i) Greater access to care: physical disabilities, geographic location, or scheduling issues.
ii) Lower costs
iii) High satisfaction: Users of quality teletherapy report high satisfaction with treatment.
iv) More privacy: in their own homes alleviates privacy concerns.
v) Tele-counselling is a darling for diaspora clients who yearn for homegrown solutions
vi) Tele counselling promotes male health positive seeking behaviour (Liu, Yang, Zhang, Xiang, Liu, & Hu, 2020).

Challenges

Whilst tele-counselling has many notable advantages there are also some drawbacks attendant with such a counselling style. Some of the noted challenges that have been summarised below:

i) working with children who have been abused, neglected, or otherwise traumatised
ii) children have not yet fully emotionally developed for effective virtual therapy.
iii) identify dissociative symptoms over a digital platform
iv) screen fatigue from being on the computer all day for work or virtual learning to endure entire sessions
v) digital divide as a potential barrier (access to ICT, for example, rural vis-a-vis urban),
vi) Many rural and peri-urban dwellers do not use the internet. Compared to just 7% of their urban counterparts there is statistically significant difference between the rural and urban students' availability of ICT devices.
vii) can make it hard to engage during a virtual session.

Conclusions

Tele-counselling has proven itself to be an effective form of therapy and has some benefits over in-person therapy. For example, the client can access a therapist who is not local. Diaspora clients can also benefit from their family therapists from anywhere without travelling back home. Tele-counselling has brought a paradigm shift from traditional physical health-focused

programmes to more holistic, flexible, and personalised solutions that expand the scope of health, addressing broader clients' needs, and promotes inclusivity in wellness. This technology-based and non-physical intervention demonstrates a progressive move towards meeting clients' diverse and evolving needs, whilst promoting a personalised mental health experience. It is envisaged that, in the near future, many people will probably switch to a hybrid model that combines teletherapy with some in-person counselling. However, tele-counselling eliminates the social activity and physical closeness that facilitates the establishment of rapport whose empathetic flavour is pivotal in healing. Permanently replacing traditional therapy with tele-therapy beyond COVID-19 could also result in feelings of loneliness and isolation that many people were experiencing before the pandemic. Therefore, a combination of online and in-person therapy may be a good long-term solution. Consequently, a strong recommendation for a hybrid approach would be in the best interest of all stakeholders such as clients, practitioners and the profession at large.

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Tele-health Services in the Post-COVID-19 Pandemic Era: The Zimbabwean Context

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Abstract

Tele-health has the potential to make health services more effective, organised and accessible. This paper aims to explore the benefits of adopting tele-healthcare in the post-COVID-I9 era. The advent of the COVID-19 pandemic gave an opportunity to innovation such as embracing telehealth services whereby health-care providers could virtually reach their clientele using telecommunication technology. A qualitative study was conducted using the exploratory design. Semi-structured interviews were administered to ten youths who were purposively selected and willing to participate in the study. Data was coded, categorised and thematically analysed. The findings revealed that tele-healthcare was understood as the virtually delivery of healthcare services using telecommunication technology. The modes commonly used are messaging applications, video conferencing and phone calls. The results also show that tele-healthcare is cost effective, it allows for easy exchange of medical information between patients and service providers and increases access to healthcare. The benefits of telehealth services include providing practitioners the opportunity to attend to more patients than they would in physical consultation, increased access of healthcare services by remote patients and it also allows for more efficient ways of providing healthcare services. However, it can be a challenge in cases where internet connectivity is inefficient. It is recommended that telecommunication service providers ought to invest in internet infrastructure and broad bandwidth to reach patients in remote areas. Further recommendations for health service providers include educating communities on the benefits of tele-healthcare through public health campaigns, community out reaches and school-based education programmes.

Keywords: Benefits, health practitioners, patients, post-COVID-19, service providers, tele-healthcare

Introduction and background

One of the most significant difficulties confronting humanity in the twenty-first century is making high quality healthcare available to all. The World Health Organization (WHO, 1997)

stated this goal in its health for all agenda for the twenty first century. Realising this vision has been deemed difficult, if not impossible, due to the burdens imposed on a growing global population by old and new diseases, rising health expectations, and socioeconomic conditions that have, if anything, increased health disparities between and within countries (Craig & Patterson, 2005). According to Guadros et al. (2024), tele-health, which uses digital technology for healthcare services, has transformative potential, particularly in underprivileged areas.

Craig and Patterson (2005) describe telemedicine as the delivery of healthcare and the exchange of medical information over long distances. It is neither a technology nor a distinct or new branch of medicine. It is the use of telecommunications and information technology to deliver healthcare services remotely (Kokori, 2023). The advancement of technology and connectivity enhances access to quality healthcare, reduces healthcare inequities, and overcomes geographical barriers by connecting patients and clinicians regardless of location (Musuka et al., 2024). This can make healthcare services accessible in the context of Zimbabwe, where the majority of patients live far away from healthcare services.

Tele-health enables continuous care through remote monitoring and virtual consultations, improves health outcomes, and promotes collaboration among healthcare experts, hence expanding services to underserved areas. Its novel strategy combats the paucity of healthcare providers, improves prompt and appropriate service, and reduces commuting by patients. Its novel strategy counteracts the scarcity of healthcare professionals, promotes prompt and suitable care, saves patients' travel times, minimises hospital stays, and facilitates healthcare access from home (Khavrat et al., 2020).

This patient centred strategy not only saves resources, but it also puts patients at the centre of the healthcare experience. Some studies have verified tele-health's ability to deliver primary healthcare services on par with traditional approaches across multiple domains, demonstrating its potential to reduce healthcare inequities (Gorodesk et al., 2020). However, current concerns indicate rising health disparities caused by tele-health, particularly in the context of the COVID-19 pandemic (Wijesooriya et al., 2020).

Barriers to extensive tele-health implementation in the United States of America include reimbursement and regulatory concerns, patient and physician acceptance, and functioning and use friendly technology (Cahill et al., 2023). To address some of these challenges during the pandemic, the US Department of Health and Human Services (DHHS) temporarily suspended

many of the requirements for tele-health technology, allowing tele-health services to be delivered across a variety of technology platforms (Centre for Medicare and Medicaid Services, 2020).

Tele-health models existed in Africa prior to COVID-19, but their breadth was limited due to poor telecommunication infrastructure, insufficient information, and a lack of proper funding, among other factors. The COVID-19 pandemic has however accelerated the adoption of various tele-health strategies throughout the continent (Gbolahan, 2023). The limited success of numerous prototype tele-health projects in Africa during the COVID-19 pandemic has shown that, with more funding and improved infrastructure, tele-health might become a major stakeholder in the success of African health systems (Oloagun, 2023). The purpose of this research is to investigate the advantages of implementing tele-healthcare in the Zimbabwean environment following the COVID-I9 pandemic.

Conceptual framework

Prior to the COVID-19 pandemic, it was prerequisite that the health provider and the beneficiary be present in the same location at the same time, and this made it very difficult to achieve fair access to healthcare for many people. However, recent developments in information and communication technologies in particular, have produced hitherto unseen chances for overcoming this by expanding the array of methods in which healthcare, especially following the COVID-I9 pandemic, can be provided (Patterson, 2005). This holds true for both industrialised and developing nations with feeble or unstable economies. The COVID-19 pandemic created a pressing need for remote high quality healthcare delivery, which led to a sharp rise in demand for tele-health (Smith et al., 2020).

Healthcare access is a complex issue that is directly linked to health system performance, and governments are striving hard to increase access to healthcare (Cu et al., 2021). To address healthcare access issues, all aspects and complexities must be considered. Levesque's conceptual framework of access to health, developed in 2013, offers an intriguing and comprehensive perspective through five dimensions of access and five population abilities to receive healthcare (Levesque, Harris, & Russell, 2013). The conceptual framework of access to health paradigm proposes a multidimensional view of healthcare access in the context of health systems, and such dimensions include approachability, acceptability, availability/accommodation, affordability, and appropriateness. It further considers the population's socioeconomic determinants, resulting in the incorporation of five corresponding

capacities of individuals and populations, namely perception, seeking, reaching, paying, and engaging in healthcare (Russell, Harris, & Levesque, 2013).

The paradigm may account for both health systems and patients' perspectives on access. Furthermore, it enables researchers to investigate barriers to access caused by people's abilities to perceive, seek, reach, pay, or interact (Corscadden et al., 2017). According to Levesque's concept, access is defined as the ability to identify, seek, reach, get, or use healthcare, as well as to ensure that these services meet the needs of those who require them.

Methods and materials

Research approach and design

The qualitative research approach was used in this study. The qualitative research paradigm focuses on interpreting social or human problems to uncover the underlying causes (Addo & Enoh, 2014). According to Shava and Nkengbeza (2019), qualitative research strives to get a comprehensive understanding of human behaviour and pre-existing problems. The study adopted an exploratory research design to explore the benefits of adopting telehealth service post-COVID-19 era in Mutare urban, thereby providing a Zimbabwean context. This design sought to obtain familiarity with a phenomenon and acquire new insight in order to formulate a precise problem (Stebbens, 2001). Exploratory research mainly focuses on interpretation of information that is given. Exploratory research involves a smaller sample size; the results cannot be accurately interpreted for a generalised population (Swaraj, 2019). Exploratory research was found appropriate for this study because it allowed for in-depth and contextual understanding of tele-health and the benefits of adopting the approach to healthcare provision post the COVID-19 era. Evidently, the advent of the COVID-19 pandemic challenged healthcare systems in Zimbabwe and there was a need to scale up.

Study population and sampling procedure

Semi-structured interviews were conducted with young people aged between 22 and 25 years of age domiciled in Mutare urban. Some of these youths were at tertiary institutions. A purposive sampling procedure was followed to recruit ten participants and participants were informed that their participation was voluntary and were requested to provide a verbal consent. This study used purposive sampling as it relied on the judgement of the researcher in the selection of units that were to be studied. This is because the sample being investigated was quite small. The sample size was determined by data saturation (Sundries, Lewis & Thornhill, 2012).

Data collection instrument

In this study, semi-structured interviews were used as an instrument to collect data. Ten individuals, purposively selected and willing to participate in the study, were asked pre-determined research questions. The semi-structured interview method sought in-depth explanations from participants on the research components that required more details. It had pre-determined questions, which could be amended, reworked, explained to the interviewee, or removed if situation deemed necessary (Robson, 2002). In this study, the researchers used semi-structured interviews (a qualitative research method) to gain an in-depth understanding of participants' true reflection and experience of the benefits of adopting tele-health in the post-COVID-19 era.

Additionally, semi-structured interview gave the interviewer a platform to ask follow-up questions and probe for more details (Heath, 2023). The researcher made use of a questionnaire with a mixture of close ended and open ended questions. The language used was English, which is the basic standard language in Zimbabwe. However, where there was a need for interpretation of the question and or translation, the researcher would verbally do so. According to Plumridge et al. (2012), when research requires detailed in-depth information, then active interpretation only at certain stages is appropriate and so as verbatim translation.

Data analysis

The collected data was analysed through thematic analysis. According to Crossely (2021), thematic analysis is the study of meaning patterns. Thematic analysis gives an opportunity to understand the potential of any issue more widely (Marks & Yardley 2004). Data was collected and stored in audio form. Upon analysing it, at first, the data was transcribed verbatim. Emerging themes were analysed from the collected data to determine the meaning. The research questions for the study guided the procedure. The present study employed thematic analysis on data obtained from semi-structured interviews, as it is a particularly valuable method for obtaining subjective information such as participant experiences, viewpoints, and opinions (Caulfield, 2019). Thematic analysis allowed the researcher to precisely determine the relationships between concepts and compare them with the replicated data (Namey et al., 2008).

Ethical considerations and management of data

The Research Committee of the Manicaland State University of Applied Sciences evaluated the research proposal of this study in line with the Code of Conduct for Research and the

University Policy and Research Ethics. The application was approved by the research committee and was issued Ref/ Ethical Clearance No: RBC/2024/02. This was based on the understanding that all ethical conditions related to voluntary participation, informed consent, anonymity, confidentiality of the information and the right to withdraw from the research must be explained to participants in a way that would be clearly understood. In addition, a signed letter of informed consent was to be obtained from each of the participants in the study. In preparation of the collection of data, the researchers obtained consent to collect and share data and assured the protection of the identity of the participants and their personal identifying information. The researcher enhanced trustworthiness by ensuring technical accuracy in recording and transcribing data and having prolonged engagement with the data. On reporting the findings, the researchers used extracts from participants' verbatim accounts.

Results and discussion

Understanding the meaning of healthcare

This section presents results on the participants' understanding of what healthcare is and the concept of a telehealth system.

In-person prevention, diagnosis, treatment and maintenance of health

The following excerpts show participants' understanding of the theme:

> "The term healthcare refers to the services and systems that are in place to help maintain and improve human health. These services, which are rendered to clients by healthcare professionals, are aimed at preserving one's health. They entail taking care of an individual's health all round, that is, physically, mentally, emotionally and socially. These services include the diagnosis and treatment of diseases and injuries as well as preventative measures such as health education, immunisation and screenings." **Participant 6**

> "Healthcare refers to prevention, diagnosis and treatment of illness, injury or other health related conditions. It includes a wide range of services such as primary care, specialty care, emergency care and preventive care, which can take place in a variety of settings, such as hospitals, clinics, doctor's offices and in people's homes. It can be provided by doctors, nurses, therapists and social workers." **Participant 2**

> "Healthcare refers to the maintenance or improvement of health through the prevention, diagnosis, treatment and recovery of illness, disease, injury and other physical and mental impairment in individuals. It encompasses a wide range of services provided by medical professionals and healthcare institutions to promote overall well-being and quality of life. Healthcare is the maintenance or improvement of health through treatment from nurses and doctors. It can also be defined as the prevention of disease through eating health food and exercising regularly." **Participant 11**

Remote prevention, diagnosis, treatment and maintenance of health

> "Telehealth service is administered through telecommunication. There are several ways in which telehealth services can be accessed. One of which is through what is called 'store and forward technology', where medical images and information are sent from one site to another It allows patients to consult with and receive medical care from healthcare providers virtually without having to visit a healthcare facility." **Participant 4**

> "Telehealth system is a broad term which refers to the use of telecommunication technologies to provide healthcare services. The technologies include the internet, telephone, video conferencing and mobile applications. With these technologies, patients can have virtual consultations with providers where patients receive real time monitoring of vital signs and even receive medical treatments remotely." **Participant 2**

In this study, the participants defined healthcare as services and systems that are put in place to maintain and improve human health. They indicated that these services are aimed at preventing, diagnosing, treating illness and preserving an individual's health. Patients visit healthcare facilities such as hospitals, clinics and pharmacies to seek the services of various healthcare professionals who include doctors, nurses, psychologists, pharmacists and many other professionals. The participants in this study also revealed that telehealth service has gained popularity since the COVID-19 pandemic. They perceived telehealth system as the use of telecommunication and various technologies by patients to access healthcare services; and by health practitioners using the same modes to provide healthcare services. The above definitions concur with Craig and Patterson (2005) who define telehealth as the delivery of healthcare and the exchange of healthcare information across distances and; thus, it is not a technology or a separate or new branch of medicine.

Accessing healthcare services

The researchers sought to explore the ways in which healthcare services are accessed by patients.

On-site access

This is what some of the participants said:

> "Healthcare services can be accessed through primary care which involves the initial point of contact for individuals seeking mental health services usually provided by general practitioners, family physicians or nursing practitioners. These services can also be accessed in a variety of modes which include visiting hospitals, clinics, doctor's offices, pharmacies; and some services can be accessed through the internet. Specialised care is provided by specialist for specific health conditions or diseases. Emergency care affords immediate medical attention provided in emergency situations at hospitals or care centres." **Participant 5**

> "In Zimbabwe, healthcare for young people is accessed through a combination of public and private health services. The public health system includes primary healthcare from clinics and district hospitals. These services are accessed by visiting doctors, nurses or other healthcare providers' in-person and; furthermore, by using tele-health services such as video calls or messaging apps, calling a health advice line and getting healthcare services through one's health insurance plan. Free service clinics are also run by non-profit organisations where data collection surveys and questionnaires are administered at community level to obtain substantial information about healthcare issues. The government also provides subsidised healthcare for low-income families which cover cost of some health services for children and youth." **Participant 9**

Virtual access

> "It can be accessed using video conferencing, apps and other digital platforms to remotely provide medical consultation, diagnosis, treatment, monitoring and education. Video calls can be used for consultation, and medical advice can be obtained through phone calls. Mobile health apps are also used, and these allow patients to communicate with doctors, schedule appointments, access medical records. Phone calls can be used for consultation or to get advice from doctor, and nurse messaging apps allow an individual to send and receive messages from doctor or other healthcare provider. Remote monitoring devices are also used to transmit patient data to healthcare providers for continuous monitoring. Access can be through surveys asking clients if the services they got were appropriate, effective, available, accessible and affordable." **Participant 7**

> "Telehealth services can be accessed through telemedicine apps, physical fitness apps, video conferencing platforms, remote patient monitoring devices and phones or online consultations with healthcare providers. Another way is through real time technology such as video conferencing or telemedicine where a patient and provider can interact in real time. Lastly, there is remote patient monitoring where patients' vital signs and other health data can be transmitted to a provider at a distance. This can be especially useful for patients with chronic conditions who could benefit from on-going monitoring." **Participant 10**

Participants revealed that there are two main ways of accessing healthcare services. First, there is the traditional model of visiting a doctor or a hospital for help, which Patterson (2005) deemed as one of the most difficult ways of accessing healthcare services, especially during the COVID-19 pandemic where the patient and service provider were not supposed to be in the same premise due to lockdowns or social distancing regulations. Secondly, there is tele-health, which allows patients to connect with providers virtually through online applications, video calls, text messages, call centres and websites. Consultation of healthcare practitioners from public and private facilities is done on a face-to-face basis. Some healthcare practitioners offer services remotely by scheduling appointments or accessing medical records and communicating with them for one reason or another using telemedicine and mobile health applications. Health providers also monitor patients continuously for vital signs of illness and transmit or obtain health data. Some patients seek health services remotely using messaging

application, phone calls and video conferencing. The participants also revealed that telehealth service has become acceptable since the COVID-19 pandemic and it has increased since then and become a popular mode of healthcare delivery and seeking. It has proven to be effective for people with chronic conditions and infectious diseases. Emphasis is given by studies that the COVID-19 pandemic brought about an urgent need to deliver high quality healthcare at a distance prompting a dramatic increase in tele-health (Smith et al., 2020).

Impact of telehealth services on the health system

Increased healthcare accessibility

> "Telehealth service became very popular in the lockdowns due to the COVID-19 pandemic, and healthcare centres have continued with the momentum post the COVID-19 lockdowns. It has made healthcare more accessible especially in remote and rural areas. Telehealth service has had a significant impact on accessing healthcare post the COVID-19 pandemic by reducing the risk of exposure to infectious diseases because healthcare centres have become less crowded. It provides a convenient alternative to in-person visits and enables continuity of care during and there is faster service provision. It improved monitoring of patients with chronic conditions, and reduced healthcare cost." **Participant 8**

Convenient alternative

> "The COVID -19 pandemic led to a significant increase in the use of telehealth services in Zimbabwe. The need to limit in-person contact during lockdowns due to the pandemic resulted in the development of healthcare service delivery and access modes which would allow remote consultations and access of other healthcare services. Telehealth service has had positive impact on the health systems by increasing access to healthcare services for people who live far away from healthcare facilities and those with mobility issues which makes it difficult to visit a healthcare facility in person, It further helps reduce cost by eliminating the need to travel and by allowing healthcare professionals to provide services remotely. It allows for more efficient use of healthcare facilities. Practitioners can also easily share health information with their patients." **Participant 11**

Increased cost effectiveness and efficiency

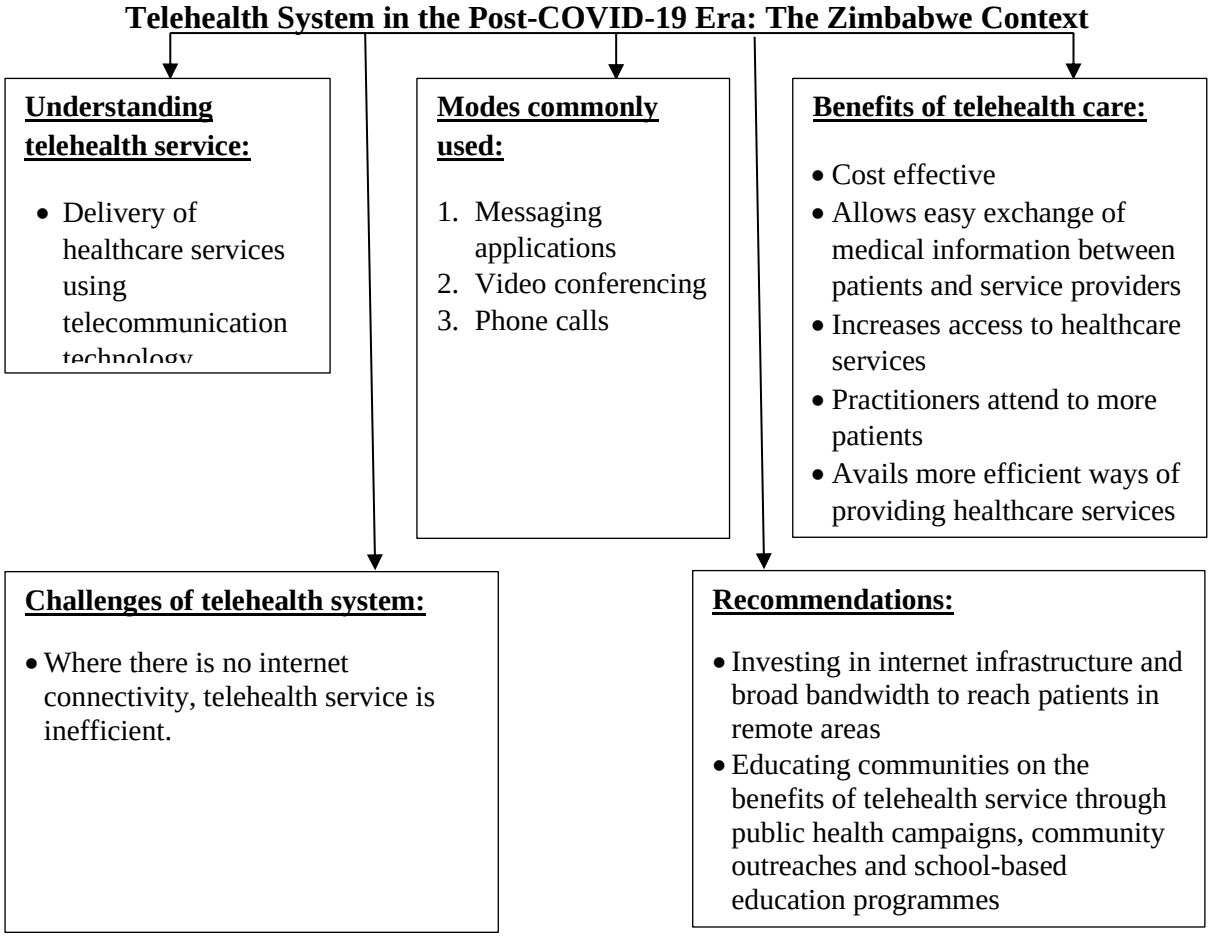
> "The Covid-19 pandemic accelerated the adoption of telehealth systems globally due to social distancing and lockdown measures. In the post-Covid 19 pandemic lockdowns, telehealth system has remained a vital tool in providing healthcare access to individuals who prefer remote consultation. Telehealth practices offer a hybrid model of delivery and access of healthcare services. It enhances the resilience of healthcare systems by reducing physical contact and potential disease transmission. It is cost effective because it reduces healthcare cost by minimising travel expenses and time off for patients. There is improved efficiency because some healthcare processes can be streamlined, for example, scheduling appointments, and follow-ups. It enhances remote monitoring and timely interventions; and this can lead better health outcomes." **Participant 3**'.

This study revealed that one of the significant impacts of telehealth service is increased accessibility of healthcare services. It can be especially beneficial to patients in rural areas

because it decreases the time spent travelling to distant healthcare facilities and, to patients with limited mobility who have difficulty travelling to a healthcare. These groups of individuals can get virtual help from the comfort of their homes. Furthermore, since the COVID-19 pandemic, medical health insurance increased the use of telehealth services in both urban and rural areas. Some participants perceived that the quality of care had improved by facilitating online communication and allowing easy exchange of information between patients and health providers. This also reduced the risk of contracting infectious disease and the spreading of these diseases. The findings of this study also revealed that a telehealth system reduces travel costs to health-care facilities because practitioners can be reached wherever there are. This study also revealed that there is now a widespread use of tele-health because a lot of people have become more comfortable with using technology to access. The above benefits to the adaptation of telehealth service concur with Guadros et al. (2024) who gave emphasis on telehealth making use of digital technology for healthcare services that offer transformative possibilities, especially for underserved regions. Kokori (2023) purport that telehealth is the use of telecommunication and information technologies to provide healthcare services remotely. Furthermore, the growth of technology and connectivity promotes access to quality healthcare, mitigates healthcare disparities, and overcomes geographic obstacles, connecting patients and providers irrespective of location (Musuka et al., 2024). A telehealth system is appropriate nowadays, especially for the young people who are glued to the techno gadgets. These could adhere to healthcare instructions easily.

Model of Telehealth System in the Post-COVID-19 Era

Table 1: Contextual Model of Telehealth System Post-COVID-19 Era



Recommendations

In this section, the participants were asked to make suggestions and recommendations to various stakeholders on exploring the benefits of adopting a telehealth system post-COVID-19 era. The participants recommended digitalisation of the entire healthcare system. This would be possibly through creating health portals and applications where patient records can be tracked. These would assist health providers with recording and better engagement with their patients. Participants also recommended sensitising the community about telehealth system as a mode of seeking healthcare services and how to access healthcare using this model. Another recommendation was to provide or increase awareness of accessing healthcare services so that people use the available platforms, for example, services healthcare call centres or online platforms. The platforms should be user friendly and easily accessible to patients. Privacy and security should be ensured on such platforms. This can be achieved through public health

community outreach programmes and awareness campaigns. It is further recommended that governments and healthcare systems should continue to support, invest in and fund public initiatives and expand telehealth services. In addition, deliberate efforts should be made to increase the availability of telehealth services to underserved populations. Health-care providers should be trained and supported in providing telehealth services. There should be ongoing research and innovation in the field of telehealth systems to alleviate any possible misconceptions about telehealth service.

Similarly, according to Gbolahan (2023), private telehealth initiatives exist in different African countries with some degree of success. Strategic collaboration between the public and private sectors could make such services available to the public at subsidised costs (*Enspire Magazine*, 2022). According to the Collaborative African Budget Reform Initiative (2020), investing in telemedicine should involve providing incentives for healthcare providers, subsidising telemedicine services for the public, or developing and expanding health insurance schemes to reduce costs and provide healthcare workers with security and worthwhile remuneration.

Conclusion

This study explored telehealth service which is understood as the virtual delivery of healthcare services using telecommunication technology. Modes commonly used are inclusive of messaging applications, video conferencing and phone calls. Benefits highlighted were that telehealth service is cost effective, allows easy exchange of medical information, increases access to health care services, practitioners attend to more patients and avails more efficient ways to provide healthcare services. Challenges highlighted included connectivity of the internet. It is therefore recommended that telecommunication service providers invest in internet infrastructure and broad bandwidth for patients in remote areas. Another recommendation includes educating communities on the benefits of telehealth services through public health campaigns, community outreaches and school-based education.

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