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CHALLENGES FACED BY PHYSIOTHERAPY PRACTITIONERS AND PATIENTS REGARDING CONTINUITY OF CARE AT THE UNIVERSITY TEACHING HOSPITALS LUSAKA, ZAMBIA.

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ABSTRACT Continuity of care is a fundamental dimension of quality of care and patient satisfaction, because it leads to quality and coordinated health care delivery, increased patient trust and confidence. To explore the challenges that patients and Physiotherapy practitioners face regarding continuity of care at the University Teaching Hospitals in Lusaka, Zambia. The study employed a phenomenological qualitative design, using in-depth interviews with eight physiotherapy practitioners and six patients with varying medical conditions, aged 18 years and above. This study used a purposive sampling technique based on the researcher's judgment of the subjects. This is a form of non-probability sampling in which decisions concerning the individuals to be included in the sample were taken by the researcher, based upon a variety of criteria, including specialist knowledge of the research issue, or capacity and willingness to participate in the research. All patients reported having multiple Physiotherapy service providers, which sometimes led to uncoordinated treatment sessions. In addition, five out of six patients cited the high cost of transport fares from their homes to the hospital and work schedules clashing with hospital appointments as most critical factors that led to discontinuity in physiotherapy care. On the other hand, physiotherapy practitioners reported difficulties following up on the progress of patients due to the functional design of the Physiotherapy department which requires them to operate from both the passive and active areas of the department. High physiotherapy practitioners' turnover per patient, long distance from patients' homes to the hospital as well as the physical demarcation of the department of Physiotherapy into active and passive treatment areas hinder continuity of care at the University Teaching Hospitals.

KEYWORDS : Challenges, Physiotherapy practitioners, Patients, continuity of care

INTRODUCTION

Continuity of care is a fundamental dimension of quality care and patient satisfaction because it leads to coordinated and coherence of care, increased trust and confidence, as well as patient adherence to treatment regimen (Ladapo et al., 2014). According to Liu et al. (2017), continuity of care can be achieved by ensuring a consistent patient healthcare provider relationship. This means that the patient sees the same healthcare provider who knows their history or keeps accurate record of their history, treatment and diagnosis so that a new provider can build upon the diagnosis and treatment that the patient has been receiving.

Factors that influence continuity of care include demographic variables, patient-healthcare professional relationship, and organizational factors (Alazri et al., 2007, Nawa, Halwindi & Hangoma, 2020). Changes in the management; including shifts, annual leaves and insurance changes undermine continuity of care (Sudhakar–Krishnan et al., 2007, Nawa 2020). Delva et al. (2011) reported that health care providers find it hard to maintain or utilize the therapeutic relationship with their patients due to clinical block rotations. As a result, patients may experience insecurity, uncertainty, feeling lost, vulnerability or mistrust and may seek alternative care or become non-compliant to treatment by withdrawing from the care system (Haggerty et al., 2013). Further, some patients feel ignored whenever they change healthcare providers and find it hard to explain their condition to every new care provider (Biringer et al., 2017).

A study conducted in the Netherlands demonstrated that poor continuity of care in general practice is associated with increased mortality of elderly patients (Maarsingh et al., 2016). Similarly, a study conducted to determine the impacts of provider continuity of care on patients with Type 2 Diabetes Mellitus in Nigeria (Udonwa et al., 2013) found a significant difference in the quality of care between adult diabetic patients with provider continuity care and patients with random care providers. There is however little information on Zambia and the University Teaching Hospitals (UTH) in particular regarding challenges patients and Physiotherapy practitioners face with continuity of care. Continuity of care is the degree to which a series of healthcare events is experienced as coherent, connected and consistent with the patient's medical needs and personal context. This study explored the three categories of continuity of care namely

relational, management and informational continuity of care. Relationship continuity refers to an ongoing trusting therapeutic relationship between the patient and one or more healthcare providers that helps to bridge healthcare episodes over time, and which links past to current and to future care (Bayliss et al., 2015). It depends on the consistency of the provider as well as an established patient-therapist relationship.

Informational continuity refers to the availability of clinical and psychosocial information across encounters and professionals (Deeny et al., 2017). It depends on the transfer of information between the patient and the health provider, as well as between providers and accumulation of knowledge of patients. The last section of the study focused on information relating to management continuity. Management continuity is the extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent (Haggerty et al., 2011). It focuses on the consistency of care and involvement of patients in the process of care. Questions were set under each of these categories in order to assess challenges faced by patients and physiotherapy practitioners, the level of continuity between the patients and physiotherapy practitioners as well as to explore the factors that hinder continuity of Physiotherapy care at UTH.

Due to scarcity of data on this topic in Zambia, our study is among the first to be conducted locally and will help service providers and policy makers to understand the challenges faced by physiotherapy practitioners and patients as regards continuity of care. This was in a bid to maintain and improve the quality of physiotherapy services and ensure patient satisfaction in the rehabilitation process (Medina-Mirapeix et al., 2011).

METHODOLOGY

This was a qualitative study using a phenomenological approach. A phenomenological approach was deemed appropriate for in-depth perceptions and personal experiences of patients and physiotherapy practitioners in relation to continuity of care and satisfaction with physiotherapy services at UTH. The study was conducted at the UTH, Lusaka Zambia. The University Teaching Hospital is the main national referral hospital in Zambia (Bulawayo et al, 2020). The department of Physiotherapy at UTH had thirty-six (36) Physiotherapy Practitioners (PPs) at the time of the study. The department attends to an average of 120 and 135 out and in-patients respectively per day, from all hospital units including; the Intensive Care, obstetrics and gynecology, internal medicine, orthopedics, trauma as well as pediatric blocks. This study used purposive sampling technique to select the sample. This is a form of non-probability sampling and often involves a deliberate choice of participants based on the qualities they possess (Etikan et al., 2016).The researcher used maximum variation type of purposive sampling in order to gain a greater insight in relation to continuity of care. PPs were varied according to the longevity of their service at UTH and only those with at least six months of work experience were included. All PPs had worked for six (6) months and confirmed by the Public Service Management Division at the time of the study. It was assumed that confirmed PPs were certified independent practitioners and thus able to work under minimal supervision. PPs were also varied according to their specialty within the profession as well as their level of education; four (4) diploma and four (4) degree trained PPs. Further, only patients (Pts) with musculoskeletal and neurological conditions who had attended physiotherapy sessions for at least three weeks and aged 18 years and above were included. In addition, all participants had to consent to the study. The maximum variability process across the two strata yielded 14 participants; consisting of six (6) Pts and

eight (8) PPs, with these numbers, the authors aimed to achieve thematic saturation for both Pts and Pps.

Pts and PPs interview guides, a tape recorder, checklist, pen and book were used to capture data from participants. The two interview guides were adopted from a continuity of care model by Haggerty et al. (2003). The tools consist of three sections addressing the three dimensions of continuity of care (relational, informational, and management continuity). These interview guides were adjusted to suit the objectives of this study and the physiotherapy setting. The tools made it easier for the researcher to employ a deductive approach to analysis along the three major thematic areas as has been highlighted in the analysis and results sections.

The interview guides were pre-tested on PPs and Pts at the University Teaching Hospital (UTH). The pilot study was conducted on two (2) Pts and three (3) PPs. Following face-toface interviews, refinements were made to the wording in the patients' interview guide as patients had difficulties understanding some questions. The Pts and PPs who participated in the pilot study were not included in the main study. To establish dependability, the researcher used an inquiry audit which included an outside person to review and examine the research process and the data analysis, in order to ensure that the findings are consistent and could be repeated. This was further compounded by disclosing the tools and methods of analysis used in the study by the researchers to the respondents. Furthermore, to prove that the data represent the information participants provided rather than inquirer imagination, data sources were triangulated to reduce the effect of researcher bias and through audit trials. To ensure transferability, the researcher endeavored to provide sufficient contextual information so as to make it possible for the study to be transferable to other settings.

All participants were provided with a copy of the consent form and information sheet and assured of their right to withdraw from the study at any time. The participants were approached and interviews scheduled at their convenient time.

In-depth interviews - Patients

Face-to-face interviews were conducted with patients who were selected and agreed to take part in the study. At the time of these interviews, the COVID-19 pandemic had not broken out, so concerns for social distancing were not yet in place. The interviews were conducted in English since all patients preferred English. The interviews were audio recorded.

In-depth interviews - Physiotherapy Practitioners

Face-to-face interviews were conducted with physiotherapy practitioners who were selected and consented to take part in the study. The interviews were audio recorded and detailed handwritten interview notes taken in an interview notebook.

Data management and analysis

All recorded interviews were stored on a password-protected computer. The audio recordings were transcribed verbatim and stored in a password-protected folder. The data was analyzed using a deductive thematic analysis method in line with the model by Haggerty (2003). Thematic analysis is a qualitative method for identifying, analyzing, organizing, describing and reporting themes found within a data set (Nowell et al., 2017). The collected data was analyzed following the six (6) phases of the thematic analysis method. According to Braun and Clarke (2006), the phases include familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the final report.

In this study, the researcher had already defined and predetermined themes prior to data analysis and the themes

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- of the study included:
- Relational continuity
- Informational continuity
- Management continuity

Field notes were read and transcribed after the interview. Two independent transcribers were engaged to transcribe the same data which was compared among the transcribers until a consensus was reached. Recorded in-depth interviews of Pts as well as PPs were listened to repeatedly in order to capture the context and meaning of the sentences. Key statements, ideas and experiences were grouped together to form codes and similar codes were grouped together. The codes were then compared for similarities and differences and grouped into themes in line with the themes in the continuity of care model by Haggerty et al. (2003). The themes linked the collected information, at the same time giving new information. If the codes that resulted from the information did not fit in any of the developed themes, a new theme was developed. These themes were reviewed at the end to make sure that they included important information that was collected. The raw data as well as the themes identified were subjected to a review by an independent person/expert to make sure that they included important information that was collected. All the coded information was read to make sure that the themes were coherent; this was done to ascertain that all the missing information was coded into relevant themes. After review, the themes were then considered to be sufficient, and then the scope of each theme was defined to tell a story about what was coded under that theme.

Ethical Clearance

Ethical clearance was sought from the Centre of Excellence in Research Ethics and Science (ERES) and the clearance number is 2018-July-024. Permission was sought from Lusaka Apex Medical University where some of the co-authors are affiliated and UTH authorities which was the study site. Participants were not deceived or forced into taking part in the study as it was clearly explained to them that their participation was voluntary, and whether they agree or refuse to take part in the study their treatment was not going to be affected in any way. Therefore, written informed consent was sought from the study participants before they took part in the study. In order to assure participants' confidentiality, no names or personal identifiers were included in the interview guides. To maintain privacy and confidentiality, patients' and therapists' interviews were conducted from treatment rooms and offices respectively. Identification of participants was only done through numerical codes and participants were free to withdraw from the interview session at any time. There was no direct benefit to the participant and every effort was made to minimize any risks.

RESULTS

Sample response rate

Å total of 14 participants were interviewed, eight (8) PPs and six (6) Pts. This yielded a 100% response rate.

Demographic characteristics of participants

A total of 14 participants were interviewed, eight (8) PPs and six (6) Pts and thematic saturation was reached after interviewing five (5) Pts and one more Pt was done while with PPs, thematic saturation was achieved at six respondents and two more were done to ensure saturation was indeed reached. The demographic data of Pts and PPs that participated in the study are respectively presented in tables 1 and 2. The Pts were aged between 22 and 45 years old while PPs were aged between 26 and 38 years. The study comprised of both male and female Pts and PPs. Four (4) out of the eight (8) PPs were Physiotherapists whereas the other four (4) were Physiotherapy Technologists. The PPs at UTH had varying duration of experience ranging from six (6) months to 16 years.

Table 1: Demographic characteristics of patients Sex Occupat Physical Level of S/ Āđe Diagnosi Treatme No (Yrs.) address education nt ion s duration 1 32 F Teacher Avondal Tertiary Parapar 1 month е esis 2 22 Μ Student Kamwal Secondary Upper 2 months limb α fracture 3 35 Μ Banker Rhodes Tertiary Sciatica 4 weeks park 4 25 F Maid Bauleni Secondary Elbow 3 weeks fracture 5 45 F Chawa Left House Secondary 3 weeks wife Shoulder mα dislocati on 6 30 М Ex-Makeni Secondary Parapleg 2 years driver iα

Table	2:	Demographic	characteristics	of	physiotherapy
practi	tioı	ners			

S/	Age	Sex	Experie	Qualificati	Specializ	Treatment
No.	(Yrs.)		nce	ons	ation	Ārea
1.	26	F	6months	Diploma	General	Passive
2.	38	Μ	16 years	Bachelor's degree	General	Passive
3.	30	F	6 years	Master's degree	Public health	Passive
4.	29	М	2 years	Diploma	General	Active
5.	26	F	2 years	Diploma	General	Active
6.	33	М	10 years	Diploma	General	Passive
7.	30	F	7 years	Bachelor's degree	General	Active
8.	27	F	2 years	Bachelor's Degree	General	Active

Relational continuity

Regarding the choice of physiotherapy practitioners, majority of patients reported being attended to by a maximum of eight (8) physiotherapy practitioners with the minimum of four (4). However, one (1) patient said they had lost count of the exact number of physiotherapy practitioners that attend to them.

"They are a lot and almost everyone in the department attends to us" (Patient A).

Similarly, physiotherapy practitioners indicated that they attend to four (4) to 15 patients per day. This in itself reflected some of the challenges physiotherapy practitioners face.

"The number varies, sometimes I see less than 10 patients, sometimes I see even up to 15 patients. The least I could see in a day is 6 patients" (**Physiotherapy practitioner** 1).

The last question on relational continuity required the patients to state whether they received the same kind of treatment from different physiotherapy practitioners. The patients reported that they received different kinds of treatment from different practitioners because each therapist had their own understanding of the same condition. "I get different treatment from different physiotherapists because each physiotherapist has their own understanding of the problem" (Patient D).

To triangulate data sources on relational continuity, the physiotherapy practitioners were asked if they saw different patients every day. All the physiotherapy practitioners reported that they attended to different patients every day because patients were given appointments on different days of the week.

"Initially, I would see the same patient but then if we are

having like wards, you would anticipate that I would see the same patients but then you would find that patients has been discharged. You would have to assess a new patient so patients change regularly, but I do follow up on the patients I have assessed because it is easier to notice a simple change in the patient if you have been attending to them and you would actually develop that physiotherapist-patient relationship after some time"

(Physiotherapy practitioner 2).

Further, most Physiotherapy practitioners reported that they took long to win their patients' trust.

"Yes, I think my patient trusts me because they have no complaint about the way I attend to them but there are cases where patients withhold information especially if it is the first time you are attending to them" (Physiotherapy Practitioner 5).

Informational continuity

Under this section, the patients were asked to state if the physiotherapy practitioner attending to them was informed about their situation and aware of their condition.

"Yes, because the first day I came here they did an assessment and I was given an appointment card. So every time I come here I give that card to the physiotherapist available before we start the treatment" (**Patient C**).

In the same vain, physiotherapy practitioners revealed that they obtain information concerning the patient's condition through patient files and interviews before, during and after treatment sessions, as well as interviews with care givers and other medical staff that have attended to those patients before.

"Through the file and during the assessment where you ask the patient, caregiver or relative." (Physiotherapy Practitioner 3)

The physiotherapy practitioners were further asked if they were always informed about the patients' previous condition.

"Most often yes, sometimes it does not come immediately because maybe the patient feels they have to withhold the information but as we continue with the treatment, they open up and start talking" (**Physiotherapy Practitioner 1**).

Lastly, the practitioners were asked how they share information about the patients' condition with other physiotherapy practitioners.

"For patients that have been coming for some time and I was not the one who assessed them, we do not normally ask because they present an appointment card. For ease of management, after an assessment we give our patients appointment cards in case I am not around then it will be easier for my colleague to work with the patient and do not have to ask about their condition every time they come. The card mostly contains the necessary information needed, the patients name, gender, diagnosis, treatment plan" (Physiotherapy Practitioner 6).

Management continuity

Under this section, the patients were first asked if the physiotherapy practitioners attending to them were skilled. The study found that only one patient said that not all of the practitioners that attend to them were skilled but overall 5 patients stated that the physiotherapy practitioners that attend to them were skilled with some of the patients pointing out that there is consistency in the treatment they receive from different physiotherapy practitioners thus they are noticing improvements in their conditions.

"They are skilled because there is consistency in their treatment, when one is not around there is always someone to help and the procedure that I have been subjected to is similar, there is no change to say today we are here tomorrow we are there" (Patient D).

Secondly, the patients were asked if they received the care they needed and the study established that most of the patients acknowledged that they received the care they needed except for one who was skeptical stating that sometimes they are forced to do exercises on their own without any assistance from management.

"Not really, sometimes I do my exercises by myself because they just tell me to go on the machines, without being assisted or managed" (Patient B).

Further, the patients were asked if they experience having to miss physiotherapy sessions and the study established that most of the participants had missed physiotherapy treatment before.

"Yes, sometimes I do not have transport money or maybe I have to go for review" (Patient E).

In conclusion, the physiotherapy practitioners mentioned that there were times when their patients did not come for treatment due to various reasons. Some of the reasons that the study uncovered were financial challenges, illness and distance to the health facility. Other patients did not attend treatment due to scheduled health reviews in other departments, although most of the patients informed the physiotherapy practitioners beforehand about their other appointments or failure to attend the treatment sessions.

DISCUSSION

In this study, majority of the patients were unemployed and had modest levels of formal education. These factors are major predictors of one's social economic wellbeing and could lead to poverty, ultimately contributing to discontinuity of physiotherapy sessions due to lack of money for transport and service charges for third level referral hospitals like UTH. Similarly, a study by Haung et al. (2014), found that unemployed individuals and their families face the challenge of accessing health services, as well as poor health status due to a lack of liquidity or disposable income. The study participants included patients with different conditions therefore, the treatment durations varied with three (3) weeks being the shortest treatment period and two (2) years being the longest period.

The study found that majority of the patients had more than one physiotherapy practitioners attending to them. This is akin to the findings of the study by Medina-Mirapeix et al. (2017), on continuity of care in hospital rehabilitation services, which reported that patients with multiple therapists experienced feelings of mistrust and the need to remain vigilant to avoid receiving conflicting treatment. According to Haggerty et al. (2013), patients may experience insecurity, uncertainty, lostness, vulnerability or mistrust as a result they may seek alternative care, or become non-compliant to treatment by withdrawing from the care system. Further, Biringer et al. (2017) found that some patients feel ignored whenever they change healthcare providers. This statement reflects the views of one patient in the current study that said they feel they are not cared for as they are left to do exercises on their own without any assistance or management.

On obtaining patient information, the study revealed that most patients found it difficult to share information on their first visit, thus physiotherapy practitioners had to depend on appointment cards and interviews with caregivers and other medical staff with prior interaction with the patient. Similarly, a study by Jackson et al. (2017), on patients' and providers' experience on continuity of care in China, reported that the patient's chart did not provide information about their history, condition, the treatment that had been tried already and what treatment worked, hence the need for patients to repeat the same information about their condition whenever they were seeing a new provider. However, most health care providers fail to obtain information from some patients for reasons reported by Haggerty et al. (2013), which leads to patients seeking alternative care, or becoming non-compliant to treatment by withdrawing from the care system.

The findings of this study also show that some physiotherapy practitioners find it difficult to follow up and assess the progress of their patients due to the structural design of the department of physiotherapy at UTH, which has been partitioned into passive and active treatment wings. The design of the department appears to hinder continuity of care as a physiotherapy practitioner in the passive wing only does part of the treatment and refers the patient to a colleague in the active wing for exercises. According to Jackson et al. (2016), problems with continuity of care are more a consequence of how the health system is structured than the practice of individual health care providers. This statement reaffirms the need to enhance human performance factors such as institutional facilities, environment and tools (Nawa, 2019). As reported elsewhere (Alazri et al., 2007), continuity of care is partly influenced by factors related to healthcare professionals and organizational factors.

Continuity of care is associated with a sustainable relationship between care providers and patients. It is an interpersonal and service relationship, which requires mutual trust, an attitude of respect for clients and their right to confidentiality (Burge et al., 2011). The current study found that patients were usually attended to by more than one physiotherapy practitioner since they started treatment which brings into question issues around relational continuity of care when different practitioners attend to the same patient in successive visits. Additionally, the study discovered that most of the patients received the same kind of treatment while some mentioned that they received different treatment from different practitioners because each therapist had their own understanding of the same condition.

To this end, patients felt that having one or two therapists during one's treatment period would be desirable because he/she would be able to track the progress that one has made than getting new exercises every time. As also reported by Alazri et al. (2007), continuity of care is influenced by factors related to patients and healthcare professionals, patienthealthcare professional relationship and organizational factors.

Several factors were highlighted by participants. One of the main challenges patients faced was financial difficulties. Almost all patients and physiotherapy practitioners mentioned lack of money for transport as a major reason why patients miss physiotherapy sessions. In addition, the study established that most of the participants had missed physiotherapy treatment sessions before due to various reasons such as work obligations, distance from their homes to the hospital, other appointments and health reasons. Additionally, some patients were unable to attend physiotherapy due to absence of caregivers to take them to the hospital, especially wheelchair bound patients. Therefore, the study reaffirms the statement that socioeconomic and demographic characteristics of patients affect continuity of care (Alazri et al., 2007, Mpundu et al., 2021).

CONCLUSION

Overall, the study found that patients were seen by multiple physiotherapy practitioners during their treatment period. According to the patients that participated in this study, involvement of multiple physiotherapy practitioners in one's treatment cycle hinders continuity of care by compromising quality of care due to possible competence variations among practitioners. Further, the study revealed that most patients found it difficult to share information on their first visit due to feeling of mistrust and neglect, thereby denying the practitioner the necessary information needed for effective patient management. However, according to the physiotherapy practitioners at UTH, continuity of care was hindered by a wall demarcating the department into active and passive treatment wings, affecting follow up and assessment of patient progress. Most patients reported that lack of finances to meet the cost of transport was one of the factors that led to discontinuity in physiotherapy care. Additionally, demographic factors such as distance from the patients' homes to the hospital as well as factors such as work obligations, the patient's health status and schedule clash with other hospitals or departments were found to be some of the factors that hinder continuity of care. The researchers considered both dimensions and perspectives of quality according to patients and physiotherapy providers.

Recommendations

The UTH management should consider mainstreaming and strengthening individualized care/relational continuity policies. This will lead to greater clinical awareness of patients, with increased knowledge, greater trust, better outcomes and higher patient satisfaction. Although the Ministry of Health in Zambia has introduced physiotherapy services in all first level referral hospitals in Lusaka; there would be need for more departments of physiotherapy at clinic level, so as to increase access to affordable physiotherapy services. It is envisaged that this will help increase attendance and ultimately improve treatment continuations. Future research should focus on quantitative methods so that bigger numbers of patients and physiotherapy practitioners could participate. In addition, a comparative study involving other facilities in Lusaka apart from UTH would give insight into the magnitude of the problem.

Limitations of the study

The study only focused on one institution- UTH. Therefore, the findings from the study cannot be generalized to other health facilities. However, valuable information has been generated concerning challenges faced by physiotherapy practitioners and patients on continuity of care at UTH physiotherapy outpatient department. Another limitation is that this study excluded the pediatrics department therefore the findings of the study cannot be generalized to all departments at UTH. Furthermore, the nature (qualitative) of the study makes external validity (generalizability) inapplicable.

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