



Understanding health worker incentives in post-crisis settings: policies to attract and retain health workers in rural areas in Zimbabwe since 1997, a document review

Yotamu Chirwa (ychirwa@brti.co.zw); Wilson Mashange (wmashange@brti.co.zw), Pamela Chandiwana (pchandiwana@brti.co.zw); Stephen Buzuzi (sbuzuzi@yahoo.com); Shungu Munyati (shungu@brti.co.zw); Brian Chandiwana, (chandiwanab@gmail.com); Sophie Witter (sophiewitter@blueyonder.co.uk)

Table of Contents

Acronyms	5
Acknowledgements.....	7
Executive Summary.....	8
Introduction	11
Background to the research.....	11
Rationale	11
Gaps in previous research.....	13
Objectives of the study	14
Research methods	14
Search strategy	14
Number and type of documents reviewed.....	15
Government - wide policy documents.....	15
International development partners' reports	15
MoHCW and HSB sectoral policies HRH specific policy documents and development plans	15
Academic publications and discussion papers.....	17
Results of the literature search.....	17
Thematic analysis.....	18
Study limitations and gaps.....	18
Results.....	Error! Bookmark not defined.
Findings	19
The context and HRH challenges during and post-crisis.....	19
Recruitment, health worker distribution challenges and workloads	21
Remuneration allowances, private practice and systems of promotion.....	26
Job security and Training opportunities	28
Policy Responses: Recruitment, remuneration, retention incentives and performance management.	29
Recruitment	29
Remuneration and allowances	33
Retention	34
Performance Management.....	34
Effects and effectiveness of the policies.....	36
Conclusions	38
Lessons learnt	38

References 40

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral treatment
CAG	Consortium Advisory Group
CMED	Central Mechanical and Equipment Department
DFID	Department for International Development (UK)
DMO	District Medical Officer
DNO	District Nursing Officer
EHP	Environmental Health Practitioner
EHTs	Environmental Health Technicians
EPI	Expanded Programme for Immunisation
ESAP	Economic Structural Adjustment Programme
EU	European Union
GMOs	General Medical Officers
GNU	Government of National Unity
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSB	Health Service Board
IDIs	In-Depth Interviews
KIIs	Key Informant Interviews
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoF	Ministry of Finance
MoHCW	Ministry of Health and Child Welfare
MoHCC	Ministry of Health and Child Care
MRCZ	Medical Research council of Zimbabwe
MTP	Medium Term Plan
NHIS	National Health Information System
NGO	Non-Government Organization

NHIFA	National Integrated Health Facility Assessment
PCN	Primary Care Nurse
PHC	Primary Health Care
PMD	Provincial Medical Director
PNO	Principal Nursing Officer
PSC	Public Service Commission
RBM	Results Based Management
RCZ	Research Council of Zimbabwe
RGN	Registered General Nurse
SCN	State Certified Nurse
SSB	Salary Services Bureau
STERP	Short Term Emergency Recovery Program
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VHSSP	Vital Health Services Support Programme (EU)
WHO	World Health Organization
ZACH	Zimbabwe Association of Church-related Hospitals

Acknowledgements

This study would not have been possible without the contribution of the permanent secretary in the then Ministry of Health and Child Welfare, now the Ministry of Health and Child Care, who authorised access to the ministry library, and the members of staff in the health ministry who shared documents and literature with the research team. We also want to thank our Consortium Advisory Group member who gave direction and assisted the team access to key players in the Ministry of Health. In addition, we would like to thank the Liverpool School of Medicine, the International Health Group at Queen Margaret University and the ReBUILD Consortium, for their collaboration throughout the research process, especially in accessing key literature resources. Finally we want to thank the Department for International Development, United Kingdom, who funded the study.

Executive summary

Introduction

Zimbabwe's health sector is weighed down by a host of challenges caused by a decade of economic, social and political crisis. Ensuring the availability of human resources for health (HRH) in the aftermath of such a severe socio-economic crisis is a complex process. This document review examines HRH policies formulated from 1997 to date. It discusses the reasons why the policies were introduced, how they have been implemented and the effects of the policy changes prior to the crisis, during the crisis and in the post-crisis period. The document and literature review contributes to a wider study that aims to understand incentive environments for HRH post-crisis and their effects on health worker distribution. It will hopefully contribute to better decision-making for health workforce policies in post-conflict and post-crisis settings.

Research methods

Documents from the government of Zimbabwe, Ministry of Health and Child Welfare/Health Services Board and international development partners (e.g. WHO, DFID, USAID, UNICEF) were reviewed. Documents were acquired from the websites of these organisations or directly from their offices when the required documents could not be accessed online. WHO statistical databases e.g. the Global Health Observatory data repository, were also reviewed. A number of bibliographic databases were searched using HINARI, Google e-books and Google Scholar to identify academic resources on HRH in Zimbabwe. Online resources for international organisations were searched and grey literature and relevant references in sourced literature were checked. Research publications and discussion papers were also reviewed. The initial search terms were human resources for health, HRH attraction, retention, equitable distribution and HRH performance management combined with Zimbabwe. The web search was widened to include maldistribution of HRH, brain drain in the health services sector, economic crises, and health systems. In total, we identified 76 documents to include in the study.

Findings

The documents acknowledged that there was an HRH crisis in Zimbabwe from pre- independence. When independence was gained, the crisis worsened as a result of the equity in health policy, which saw rapid expansion of health services to previously neglected rural areas. The documents reviewed show that a progressive deterioration in the situation of HRH was apparent right up to the late 1990s, the period agreed to be the beginning of the intensification of the economic meltdown. In 1999 the presidential review commission into the health sector pointed out that there was a need to review health sector management through the establishment of a commission separate from the public service commission. However, the recommendations of the commission were not implemented with urgency, resulting in deterioration of the entire health system.

Most policies related to HRH attraction, retention and remuneration introduced in the early years of the crisis suffered from poor funding and lack of support from other government ministries. Literature and reports of the HSB indicate that the Ministry of Finance and the Ministry of Public

Service inhibited progress towards improving conditions of the health workforce, citing public service regulations and lack of financial resources as their reasoning. It was argued that singling out the health service might create problems for the government. Hence there were policy inconsistencies related to this, exemplified by the increases in allowances and reversals of these increases after short periods of implementation.

Recruitment and retention became a challenge as attrition of health workers grew. Vacancies for senior staff amassed in the public sector, as experienced staff in underserved areas would be moved to fill in the vacant posts in large, mostly urban facilities, leaving underserved areas with unfilled posts. Generally this trend has continued in the post-crisis period, leaving the public, mission and rural district council facilities with less experienced and motivated cadres. The performance management system introduced to reward health workers did not improve matters as it was poorly implemented. It was abandoned and another system, the Results Based Management, was introduced in 2005. This system was rolled out slowly and seems to be suffering from the same challenges faced by its predecessor.

In general, the document review indicates that as recruitment became difficult, the remaining health workers had to contend with heavy workloads that worsened the level of motivation and spurred resignations. Information on private practice was limited, but available works indicate that many doctors engage in private practice well beyond the permitted levels. HRH challenges mean it is impossible to enforce the regulations as this would drive away the few doctors coming as senior consultants to public sector facilities. Training is a very important aspect of retention but literature indicates that corruption has set in, in the mediation of training opportunities and access to manpower development funds. There is a general feeling that medical doctors are favoured more by the existing training and promotion policies.

The effects of the policies have been varied with most pre-crisis and crisis policies having had no impact because of lack of wide consultation, poor funding and lack of monitoring and evaluation. The policies on retention, including the introduction of allowances and improvement of existing allowances, had differential effects. In the short term, increases raised the levels motivation but because the policies were not funded well, the long term effects were negative.

Conclusions

Attracting and retaining HRH continues to pose serious challenges to the health sector in post-crisis Zimbabwe. Numerous policies formulated since 1997, when the crisis began to manifest, through the crisis and up to the post-crisis period have had limited impact on the HRH challenges. Poor funding of policies is cited as a key cause of policy failure during and after the crisis. Some of the literature asserts that the migration of health workers with managerial skills made it difficult to implement policies that would have helped retain health workers, e.g. performance appraisals. Evaluation and monitoring of previous policies has not been a priority. New policies have been crafted because the previous ones needed to be replaced. However, where evaluations have been done, the findings of the evaluation seem not to have been referred to in the next policy. Rivalries between different ministries led to the failure of HRH policies, through arguments against initiatives to make HRH conditions better. The most important outcome from this document review is that

remuneration stands out as the single most important factor influencing health worker behaviour. The attrition of HRH in Zimbabwe is a complex problem that requires the formulation of strong policies, sustainable funding and greater intersectoral coordination in the implementation of policies.

Lessons learnt

- Training opportunities have become a demotivating factor because of the perception that selection is not based on merit.
- Successful implementation of reforms require much more time for planning, informing and consulting health workers, and mobilising political support than was available in the Zimbabwean context.
- Successive policies have lacked a consultative process and the political buy-in from other ministries, hence the failure to secure funding for the implementation of many policies.
- Attrition rates have reduced following the implementation of the short-term retention scheme, suggesting that incentives can work to retain skilled HRH if they are professionally managed.
- Staff numbers have been reduced through emigration to other countries and also internal migration to other sectors, though this is less well documented.
- The public sector can best improve working conditions by learning from the other sectors that are attracting HRH from the public sector.
- The phased withdrawal of the emergency retention scheme has begun to revive the brain drain. There is the need for the MoHCW to work on securing replacement funding to sustain the retention allowance quickly before the attrition gains momentum.
- There is need for intensive capacity development to ensure that the human resources function is carried out by individuals with the right competencies.
- Policies should be monitored and evaluated and the findings from such processes should be made available to a wide audience rather than to a select few.

Introduction

Background to the research

There is a serious human resources crisis in the health sectors of developing countries, particularly in Africa. Fragile and conflict-affected states (FCAS), which Zimbabwe has often been categorised as, have poor health outcomes and no quick-fix solutions (MacKinon & MacLaren, 2012).

Zimbabwe's health sector is weighed down by a host of challenges caused by a decade of economic, social and political crisis. The Short Term Emergency Recovery Program (STERP) (2009) and the Human Resources for Health Policy (2010) show that the health sector has experienced sharp decreases in funding, infrastructure deterioration, loss of experienced health professionals, drug shortages, increased burden of disease and a high demand for services. These factors have inevitably led to a drastic decline in the quality of health services available for the population (MoHCW/Health Service Board, 2010; GoZ, 2009; STERP, 2009; NHIFA, 2012). Ensuring the availability of human resources for health (HRH) is a complex process. There needs to be enough health workers, with an appropriate skills mix, available at the right time and place. This process is even more difficult when the health sector needs reviving and there is political and economic uncertainty.

It is therefore unsurprising that attracting and retaining HRH continues to pose serious challenges to the health sector in Zimbabwe. A growing body of evidence suggests that the quality of a health system depends greatly on highly motivated HRH, who are satisfied with their jobs, and are therefore willing to stay at their duty stations and work hard (Kanfer, 1999; Awases et al., 2004). This document review examines HRH policies formulated from 1997 to date. It discusses the reasons why the policies were introduced, how they have been implemented and the effects of the policy changes prior to the crisis, during the crisis and in the post-crisis period. General literature on HRH discourses in Zimbabwe and surrounding regions are also reviewed to understand HRH issues such as retention, recruitment, attrition and workload distribution. This document and literature review contributes to a wider study that aims to understand incentive environments for HRH and their effects on health worker distribution. It also helps build an evidence base that will hopefully contribute to decision making for health workforce policies and planning via the comprehensive research uptake framework. The research uptake framework will depart from the traditional one of post research dissemination and take place concomitantly with the research process.

Rationale

The presidential Review Commission into the Health Sector (1999) found that the conditions of service for HRH had plummeted inexorably, since the 1990s. This resulted in the debilitating attrition of HRH. Drivers of HRH attrition included inadequate salaries, unattractive working hours, poor fringe benefits and a lack of career mobility. The situation continued to worsen despite the formulation and implementation of policies to improve in these areas. This research into health worker incentive environments is therefore important (National Health Strategy 1997–2007: 59).

Previous health research documents and reports from the Ministry of Health and Child Welfare (MoHCW), Department of International Development (DFID), United Nations Children's Fund (UNICEF), United States of Agency for International development (USAID) and World Health Organisation (WHO) have indicated that more research is needed on the kind of incentives that can help improve HRH management systems. Particular attention should focus on the dimensions of HRH management such as, compensation, attraction, retention, performance, posting and deployment. Additional attention should be paid to rural and farming areas. There is increasing demand for research into the effectiveness of multi-pronged approaches for health workforce development, such as task shifting, training and retention efforts.

The opening up of the health sector to community participation, as laid out in the Ouagadougou Declaration (2008), demands that health practitioners and researchers find solutions to the human resource difficulties being encountered in the health sector. In this regard, the Public Health Advisory Board at national level and the health committees at local level have been put in place to drive health sector reform through improved human resources management informed by research evidence. In March 2010, the Zimbabwe Health Sector Investment Case (2010-2012) identified that high impact health interventions needed research-based evidence into additional resources (human and non-human) that could be mobilised to support the health care system (MoHCW, 2010).

The Zimbabwe Health Sector Investment Case suggests that securing and maintaining human resources for health is pivotal for Zimbabwe to achieve the Millennium Development Goals (MDGs). The National Health Strategy, 'Equity and Quality in Health: A People's Right' (2009-2013) highlights the need for more research and policy reforms in the area of HRH. The Human Resources Strategic Plan (2011-2014: 12) states *"there has not been much HRH research within the last 10 years, largely due to limited resources and skills gaps. The officers who are in post are so overloaded that research has become less of a priority"*. The Medium Term Plan (MTP) (2011) further contends that one of the goals of the Government of National Unity (GNU) is to stabilize and improve the general welfare of Zimbabweans by improving health care services, improving health research and by increasing staff levels by up to 100 percent. This reinforces the need for health systems research particularly in the area of HRH. In 2010, a National Integrated Health Facility Assessment (NIHFA) assessed the availability, distribution and functional status of available human resources, medical supplies, equipment and infrastructure necessary for high coverage of quality health services. The NIHFA (2012) argues for robust research at all levels to yield specific information on gaps and needs at the operational or facility level.

There is demand for more independent research by policy makers and health practitioners to ascertain the impact of the government retention scheme on health worker migration, attraction, retention and performance. It is also imperative that the utility of the recently adopted Results Based Management (RBM) system be assessed. More information is required on the effectiveness of on-going in-house staff training programmes, bonding and role shifting. Currently policy discussions have focused on the best way to attract and retain key HRH both in urban and rural locations. Policy makers and other stakeholders are keen to understand, from evidence-based research, practical

recommendations in how to deal with post-crisis human resources challenges, particularly staff attraction and retention in underserved areas.

Gaps in previous research

There has been an implicit acceptance that the public service is unable to produce workable strategies for the retention of skilled health workers. If these strategies were successful, they would provide appropriate incentives and an enabling working environment that would make HRH stay at their duty stations and work hard. It is also acknowledged that what incentives work will vary considerably between individuals (Lin, et al, 2011). As noted by Gupta and Dal Poz (2009), and also by the National Health Strategy (1997–2007:3), not much is known about the private for profit health sector. It is important to understand what strategies attract health workers to the private rather than the public sector (Health for all Action Plan, 1986; National Health Strategy 1997–2007; Sikhosana, 2005).

The seminal post-independence government-wide policy framework ‘Growth with Equity’ (1981), the ‘Planning for Equity in Health’ white paper (1984), and the ‘Zimbabwe Health for All Action Plan’ (1986), all identified HRH attraction, retention and distribution as a major challenge for the future of the health service.

The Review Commission into the health sector (1999) reemphasised the challenge of attracting, retaining and equitably distributing health workers, but there has been no evidence of these HRH issues being aligned with existing as well as new policies (National Health Strategy, 1997–2007; National Health Strategy, 2009–2014, MoHCW & HSB, 2010; Human Resources for Health Policy, MoHCW & HSB, 2010; Human Resources for Health Strategic Plan, 2010). The changes in the social, political and economic context, both in Zimbabwe and globally, have brought unanticipated challenges to HRH planning and management. Factors affecting HRH distribution, attraction, retention and attrition are continuously changing, which makes research an imperative. Global benchmarks, such as the WHO Health Worker Density Indicator, the investment in HRH development and training indicator, and country progress towards attainment of the MDGs, make gathering periodic systematic evidence an imperative to provide solutions to challenges in attaining minimum thresholds for these global standards (MacKinon & MacLaren, 2012).

The socioeconomic crisis in Zimbabwe inhibited research and the monitoring and evaluation of policies. Resources were scarce and personnel with expertise were demotivated or not available, having left their stations for better opportunities in the private sector or overseas (NIHFA, 2012). Academic research of note covering the crisis period is credited to EQUINET discussion papers (See Mudyarabikwa & Mbengwa, 2006; Lipinge et al., 2009; Chimbari et al., 2008). Several reports and working papers have been produced on HRH incentive environments, for example Nyazema et al. (2003), who write on dual practice by HRH, and Mutizwa-Mangiza’s 1998 paper on ‘The impact of health sector reform on public sector health worker motivation in Zimbabwe’. Recent work on the brain drain in Zimbabwe is credited to the Southern African Migration Centre publication, ‘Zimbabwe’s Exodus, Crisis, Migration, Survival’ (2010). In this book, Chikanda’s (2005) chapter chronicles the underlying reasons for and the patterns of the brain drain of health professionals.

There is a dearth of evidence to rely on in making assessments of impact of past and existing policies on HRH retention, distribution and attraction during and post the crisis. The NIHFA (2012) notes that assessments carried out by the MoHCW in the three years preceding the NIHFA have generally been conducted at a high level and have often been very rapid, thus not providing specific information on HRH gaps and needs at the operational or facility level. No evaluations of previous policies exist, except academic research that provides commentaries of some of the policies.

The Gupta and Dal Poz (2009) survey and the NIHFA (2012) study contend that there was a public health sector bias in the sampling of the facilities that participated in the two studies and this constitutes a gap in knowledge which should be resolved. Much more needs to be done to understand how the various dimensions of HRH are mediated in the private sector, including remuneration, retention and performance management.

The urban-rural divide and the incentives environment for HRH in post-crisis settings is an area that needs concerted research to understand the weaknesses of the current measures to keep HRH satisfied with their jobs, and hence willing to stay at their stations. There is increasing demand for research that looks into on-the-job training needs and the impact of such training on health workers' performance.

Objectives of the study

To describe the HRH policies, the reasons for their introduction, how they have been implemented and the effects of the policy changes prior to the crisis, during the crisis and during the post-crisis period.

Research methods

The document review is part of a wider research project, led by the ReBUILD consortium, into understanding health worker environments in countries emerging from conflict or crisis.

Search strategy

Documents from the government of Zimbabwe, MoHCW/HSB and international development partners (e.g. WHO, DFID, USAID, UNICEF) were reviewed. Documents were acquired from the web sites of these organisations or directly from their offices when the required documents could not be accessed online. WHO statistical databases e.g. the Global Health Observatory data repository, were also reviewed. A range of bibliographic databases were searched using Hinari, Google e-books and Google Scholar to identify academic resources on HRH in Zimbabwe. Online resources for international organisations were searched and grey literature and relevant references in sourced literature were checked. Research publications and discussion papers were also reviewed.

The initial search terms were human resources in health, HRH attraction, retention, equitable distribution and HRH performance management combined with Zimbabwe. The web search was

widened to include maldistribution of HRH, and brain drain in the health services sector, economic crises, and health systems. Key policy documents spanning the period 1997- present were reviewed.

Number and type of documents reviewed

The review organised documents and literature into four categories.

- Government-wide policy documents.
- MoHCW / HSB sectoral policies, HRH specific policy documents and development plans.
- International development partners' reports.
- Academic publications and discussion papers.

Government - wide policy documents

The documents that were reviewed in this category are:

- Short Term Emergency Recovery Program (STERP) (2009)
- Medium Term Plan (2010–2015).
- Sub-committee on health Delivery system in Zimbabwe (2008) Policy framework for revamping the health sector Delivery system in Zimbabwe, report
- GoZ (2004) Health Service Act, Chapter 15:16,
- The Sub Committee on the Health Delivery System in Zimbabwe Policy Framework For Revamping the Health Sector Delivery system in Zimbabwe (2008)

International development partners' reports

The documents that were reviewed in this category are:

- Human Resources for Health Country Profile Zimbabwe, World Health Organisation (2010)
- WHO and MoHCW (2002) 'Humanitarian Assistance and Recovery Programme,' Rapid Needs Assessment for the Health Sector in Zimbabwe.
- European Union (2011) What The European Union And Its Member States Do For The Zimbabwean Health Sector
- World Bank (2010) World Development Indicators. World Bank, Washington DC.
- Global Observatory: (2011) World Health Organisation.
- Africa Health Workforce Observatory: Human Resources for Health Country Profile Zimbabwe (2009) Zimbabwe Health Workforce Observatory.
- Zimbabwe Health Workforce Observatory 2009. *Human Resources for Health Country Profile*. World Health Organization.

MoHCW and HSB sectoral policies HRH specific policy documents and development plans

The documents that were reviewed in this category are:

- MoHCW, Zimbabwe National Health Strategy (1997-2007)
- MoHCW, Health Human Resource master plan (1997b).
- Initiatives Inc. (1998) Ministry of Health and Child Welfare Report of the Motivational Survey

- MoHCW, UNFPA, UNICEF &WHO Assessment of Maternal and Neonatal Health Services in Zimbabwe. Final Working Draft, Zimbabwe (2005)
- MoHCW, Three Year Rolling Plan (1999-2001)
- Presidential Review into the Health Sector (1999)
- Initiatives Inc. (2000) Human Resources study – conducted for the Ministry of Health and Child Welfare (Zimbabwe).
- MoHCW, Draft Human Resources Strategy, Price Waterhouse Coopers (2001)
- MoHCW, Manpower Development Plan: Improving the Development of Human Resources for Health (2003)
- MoHCW, The Access to Health Care Services study (2007)
- MoHCW, Zimbabwe Maternal and Neonatal Health Roadmap (2007-2015)
- MoHCW, Zimbabwe HRH Situation Analysis Report (2008)
- MoHCW The National Health Strategy for Zimbabwe(2009-2013): Equity and Quality in Health: People’s Right
- MoHCW Zimbabwe National Health Profile (1999)
- MoHCW Zimbabwe National Health Profile (2000)
- MoHCW Zimbabwe National Health Profile (2004)
- MoHCW Zimbabwe National Health Profile (2005)
- MoHCW Zimbabwe National Health Profile (2006)
- MoHCW Zimbabwe National Health Profile (2007)
- MoHCW Zimbabwe National Health Profile (2008)
- MoHCW Zimbabwe National Health Profile (2000)
- MoHCW Zimbabwe National Health Profile (2000)
- Health Service Board Strategic Plan: (2005–2010)
- HSB Annual Report, (2005).
- HSB Annual Report, (2006).
- HSB Annual Report, (2007).
- Health Service Board (HSB) Annual Report (2010)
- Health Service Board Annual Report (2011)
- The Zimbabwe Health Sector Investment Case: Accelerating progress towards the Millennium Development Goals (2010-2012)
- Health Service Board Strategic Plan (2011-2014)
- Human Resources for Health Strategic Plan (2010- 2014)
- Human Resources for Health Policy (2010-2014)
- Performance Management System (1995)
- The Bonding Policy for Nurses (1997)
- Human Resources for Health Retention Policy (2008)
- Human Resources for Health Retention Policy (2010)
- Zimbabwe: National Health Profile (1997)
- Zimbabwe: National Health Profile (1998)
- Zimbabwe: National Health Profile (1999)
- Zimbabwe: National Health Profile (2000)

- Zimbabwe: National Health Profile (2001)
- Zimbabwe: National Health Profile (2002)
- Zimbabwe: National Health Profile (2004)
- Zimbabwe: National Health Profile (2005)
- Zimbabwe: National Health Profile (2006)
- Zimbabwe: National Health Profile (2007)
- Zimbabwe: National Health Profile (2008)

Academic publications and discussion papers

Academic publications and discussion papers that have been conducted on HRH attraction, retention, distribution and performance in Zimbabwe and other countries are:

- Mapanga & Mapanga, A Perspective Of Nursing In Zimbabwe.
- Mudyarabikwa & Mbengwa, Distribution of health workers in Zimbabwe: A challenge for equity in health.
- Lipinge et al, Policies and incentives for health worker retention in east and southern Africa: Learning from country research.
- Dambisya, A review of non-financial incentives for health worker retention in east and southern Africa.
- Dambisya et al, Health worker retention and migration in Africa - Implications for Sustaining Health Systems.
- Crush and Tevera, Exodus, Crisis, Migration and Survival
- Chikanda, Medical Leave: The Exodus of Health Professionals from Zimbabwe.
- Awases et al, Migration of Health Professionals in Six Countries: A Synthesis Report.
- Chen et al., Human resources for health: overcoming the crisis.
- Musiyambiri, An Evaluation of the Performance Appraisal System of the Ministry of Health and Child Welfare
- Mutiswa & Mbengwa, Human resource policies and equity in health in southern Africa
- EQUINET, Health Systems Trust, Equity in the distribution of health personnel in Southern Africa
- Dormael et al., Human Resources for Health: Confronting complexity and diversity
- de Castella, Health workers struggle to provide care in Zimbabwe; Brain drain adds to woes of a cash-strapped health-care system.
- MacKinnon & MacLaren, Human Resources for Health challenges in fragile states: Evidence from Sierra Leone, South Sudan and Zimbabwe.
- Dal Poz et al., Counting health workers: definitions, data, methods and global results.
- Sikhosana, Challenges in Reforming the Health Sector in Africa.

Results of the literature search

A large number of policies, reports and assessments on HRH from the government of Zimbabwe, MoHCW/HSB and international development partners were identified during the search. Numerous academic research articles and discussion papers on HRH were also identified.

In total, we identified 76 documents to include in the study. Some of the earlier documents were hard copies that were scanned or photocopied. Other documents were downloaded from web pages of organisations and some MoHCW documents were in electronic form which had been forwarded to us via email after making formal requests.

Thematic analysis

A thorough review of literature was undertaken using a pre-prepared grid of topics as listed below.

- Pre-service training
- Recruitment policies
- Management of staff
- Workload and working hours
- Remuneration
- Working conditions
- System of promotion
- In-service Training opportunity
- Job security

These key themes informed the analysis for all of the documents that were reviewed. The analysis established whether the document or policy discussed a particular theme and subsequently whether it was worthwhile including the document or policy in the review.

Study limitations and gaps

Accessing some of the critical documents was a long process and some key documents could not be found at all. There are assessments and situational analyses that were conducted by or on behalf of the MoHCW which we were not able to access because no one had them. These include the Ministry of Health and Child Welfare Report of the Motivational Survey and the Human Resources Study conducted by Initiatives Inc. However, these are referred to in secondary sources that were reviewed. After the recent HRH Situation in 2001, the MoHCW subcontracted Price Waterhouse Coopers to draft a Human Resources Strategy. This was unavailable and yet critical to understanding the issues that were identified and the recommendations proposed (Manpower Development Plan, 2003). The Humanitarian Assistance and Recovery Programme: Rapid Needs Assessment for the Health Sector in Zimbabwe conducted by WHO and MoHCW in 2002, was also not available. There are Health Service Board annual reports for 2008 and 2009 that are inaccessible, yet they hold important insights into the challenges of the health sector. There were gaps in the availability and accuracy of National Health Profile data. Perusal of the National Health Profiles shows a decline in the completeness of the information provided on staffing. For example the 1997- 1998 National Health Profile has some data on the staffing of doctors, nurses/midwives and environmental health staff. However, since 1998, staffing data is not available for the entire public sector and all the other providers do not seem to be captured. The 2003 national health profile is not available and according to the Health Information System (HIS) unit in the MoHCW, it was never produced. Data for 2009- 2012 is yet to be collated and analysed (Zimbabwe National Health Profile 1997, 1998, 2004).

The non-availability of important sources of information is not a new phenomenon in Zimbabwe. MacKinnon and MacLaren (2012) assert that constructing a reliable picture of the HRH situation in Zimbabwe presents challenges due to the lack of comprehensive and up-to-date data and statistics. The MoHCW suffers from weak health information systems where patient and community health data are not regularly collected, analysed and documented. The other limitation is that very little independent research into HR has been carried in Zimbabwe, particularly during the crisis years (MTP, 2011:183).

No policy documents from other stakeholders providing health care were reviewed e.g. for profit private providers, municipality and local authority providers in rural areas, Zimbabwe Association of Church related hospitals (ZACH) and industrial based providers. These providers are heterogeneous and it would be more practical to review the documents of each of the specific providers separately.

Findings

The context and HRH challenges during and post-crisis

At the onset of independence in 1980, Zimbabwe's health system had a highly developed urban health sector and a poor rural health sector. The health system for the urban sector was further differentiated, with the affluent white minority enjoying a health status on par with developed country standards, while the African urban dweller had poorer health status although slightly better than their counterparts in the rural areas (MoHCW, 1981, Sanders,1990). The new government set about addressing this inequity by expanding the rural health sector in line with the adopted Primary Health Care (PHC) approach. The Health for All Action Plan (1986) sought to remove racial inequities from the health system. This reformation of the health sector from the mid-1980s to 1990s, gave rise to serious challenges in HRH recruitment, distribution, retention and performance management. The large scale expansion of the health sector was accompanied by an increased budget, biased towards curative health services. However, no money was directly allocated to improving remuneration and the general working conditions for health workers. The reason for this was that the increased budget was mostly supported by development partners and hence focused on service provision (National Health Strategy 1997-2007:53; MoHCW HRH Situation Analysis, 2008). HRH challenges started during this transformation of the health sector and have increased exponentially in subsequent years, as no initiatives to improve conditions of service have been implemented. Any attempts to improve the HRH situation have always been executed as part of a wider initiative to improve civil service conditions of service as a whole. The challenges reached a peak around 2007, when the first attempt to address HRH as a specific group was made. This was reversed after three months. The second attempt was in 2009 with the Global Fund supported retention allowance and the housing and transport allowances (HSB Annual Report, 2010; HSB Annual Report, 2011).

The decade long socioeconomic crisis caused the decline of Zimbabwe's Gross Domestic Product (GDP), which affected all dimensions of the health sector. Zimbabwe's annual real GDP growth has suffered declines averaging - 5.9% since 2000. Cumulatively, output declined by more than 40%

between 2000 and 2007 (STERP, 2009:28; MTP, 2011:179). Increasingly, the government was forced to reduce funds allocated to the health sector leading to reduced capacity to purchase commodities and essential medical equipment, pay wages for HRH, and to support other activities that would promote better health service provision. The decade long socioeconomic crisis led to unprecedented attrition of HRH and hence a lack of capacity to deliver comprehensive services across the country (World Bank 2010; MTP, 2011; HSB, 2007).

The major reasons for the shortage of HRH were the post-independence expansion of the health system and a loss of HRH to the private sector. The raft of measures adopted to address the HRH shortage in the Health for All Action plan included:

- Introducing a Manpower Training and Development Programme, steered by a training coordinator.
- Making accurate and up to date information on staffing patterns and activities available.
- Widening the recruitment drive to include hitherto excluded rural areas to ensure the recruitment of cadres that were able to work in rural settings.
- Creating a Recruitment Officer post in each province.
- Including staff accommodation in the architectural plans of new health centres.
- Undertaking a national review of all HRH categories to ensure career mobility.
- Introducing a bonding system to be worked on with the MoH.
- Providing in-service training to be coordinated by the Provincial Medical Director (Zimbabwe Health for All Action Plan, 1986).

Although these were good policy positions, the Health for All Action Plan (1986) was not supported by a clear budget line. With regards to funding for plan, the policy states that the MoH will institute a new system for the planning of resources to support the primary health care approach. It further notes that an essential component will be a revised budgeting system that will be developed to ensure the channelling of funds to primary level activities. Therefore the funding for the various components of the plan was left to be worked out later. The fact that there is no mention of the funding arrangements for the specific measures outlined meant that funding would come from the traditional budget allocations which would ordinarily involve horse trading with other government priorities (Health For All Action Plan, 1986).

According to the Health for All Action Plan, all of these measures were to receive the highest priority. However two and half decades later, the HRH problems that the plan sought to address are accentuated. Some of the measures, such as the development of a bonding mechanism, were only introduced in 1997 when the attrition of HRH had become serious (Chikanda, 2010; Mutizwa-Mangiza, 1998). This was done in a reactive manner and as a result failed to yield desired result of stemming HRH attrition.

The HRH crisis continued to receive priority from the government of Zimbabwe and development partners prior to, during and after the crisis. Realising that the attrition of HRH was the biggest threat to health service delivery, the MoHCW and development partners responded by

commissioning critical assessments of the causal factors to build the evidence base to plan and manage the health sector (see Initiatives Inc., 1999; Review Commission into the Health Sector, 1999; Initiatives Inc., 2000; MoHCW, 2003; WHO & MoHCW, 2002; WHO, 2010; Public Service Payroll and Skills Audit, 2009). In all of these assessments, the consistently emerging issue was that HRH attrition is a threat to future health service delivery and leads to maldistribution of health workers. This can then undermine the goal of the MoHCW to provide equitable, effective and quality health services. The results of the Ernst & Young Public Service Payroll and Skills Audit (2009) and the HSB & MoHCW Public service Payroll and Skills Audit and Re-verification Exercise (2010) have never been made public, although the HSB annual report (2011) indicates that the results have been forwarded to the Ministry of Public Service.

Recruitment, health worker distribution challenges and workloads

The crisis period (1997-2008) was characterised by a severe shortage of all categories of HRH. During the same time, the quality of data on HRH distribution was affected drastically and planning for human resources became quite difficult (National Health Information Strategy, 2009-2014). An assessment of factors affecting the functioning of the National Health Information System (NHIS), commissioned in 2005, revealed that the NHIS was affected by:

- Lack of a central repository or data warehouse for integrating Health Information System (HIS) data sources.
- Inadequate information and communication infrastructure.
- Unclear accountability and responsibility.
- Inadequate analysis and use of information (National Health Information Strategy, 2009-2015)

These are some, but not all, of the key challenges afflicting the HIS. These challenges were identified in the Health for All Action Plan (1986) as requiring particular attention. Almost two decades later, the capacity to produce accurate data on staffing patterns is still a challenge.

The National Health Profiles, which are key sources of data for policy creation, monitoring the performance of the health sector, staff skills, and distribution patterns, depict the inadequacy of the NHIS very vividly. The National Health Profile (2000) indicates that data for 1998 on distribution of doctors was either not collected or is still to be analysed for four provinces. Staffing data reflects serious gaps in key areas and one cannot assess the vacancy rates as well as the geographical distribution of health workers or the skills mix of available HRH.

There is an improvement in 1999 data although the statistics are still difficult to reconcile. The situation has worsened since 2004 when the staffing data became very scanty and was not disaggregated by province. Decision-making for pro-poor health provision is difficult, particularly for the underserved rural areas, with such incomplete data. The National Health Profiles for 2004, 2005, 2006, 2007 and 2008 do not provide disaggregated data by cadre and province, indicating a huge challenge for the HIS in the MoHCW. It is difficult to establish the effectiveness of HRH recruitment and planning given this poor NHIS data. However, this could be the reason why there were

numerous rapid assessments over this period. The proliferation of assessments may have been to make up for the inadequacies of routine staffing data. The period 1998 to 2008 saw the commissioning of the following assessments; Initiatives Inc. (1998); Ministry of Health and Child Welfare Report of the Motivational Survey Initiatives Inc Human Resources study (2000), 'Humanitarian Assistance and Recovery Programme,' Rapid Needs Assessment for the Health Sector in Zimbabwe (2002), Assessment of Maternal and Neonatal Health Services in Zimbabwe (2005), Access to Health Care Services Study (2007), Access to Health Care Services Study (2008) and MoHCW Zimbabwe HRH Situation Analysis Report (2008). There were seven assessments commissioned in a decade.

The Maternal and Neonatal Health Services Assessment conducted in 2004 found that there were serious shortages of nurses and midwives at the primary levels of care: 40% of primary facilities had no nurse and 50% had no midwife (MoHCW, UNFPA, UNICEF & WHO, 2005). This represents a marked deterioration in the distribution of critical health cadres.

The National Health Strategic Plan 19997-2007 notes that the distribution of health personnel was biased towards urban areas. While 66% of doctors worked in the four central hospitals, only 12% worked in the rural areas. The doctor population ratio in Harare and Bulawayo was just under 1: 4000 whilst in rural areas the ratio was 1: 62000. Only 32% of the nursing cadres worked in rural health services, compared to 34% who worked in the central hospitals in the 1990s. While the statistics presented here define a crude urban-rural bias, they nevertheless indicate more critical health workers were available in the 1990s than at the time of the Maternal and Neonatal Health Services Assessment in 2004. The assessment indicates the dire state of HRH distribution compared to the situation in the 1990s. One can only assume that very little has been done to improve HRH availability by the government in the past because of an overreliance on development partners' support.

In the early years of independence, international organisations seconded doctors and other specialists to Zimbabwe. Unfortunately, nurses and midwives were not among these expatriates and yet they constituted the first level of service for rural users. In 1998, 65% of medical posts outside the major cities were held by expatriate doctors (Herald, 18/7/98; cited in Mutizwa- Mangiza, 1998).

In order to manage complications beyond the midwives' capacity, a standard presence of two General Medical Officers (GMOs) is required at the secondary level health facilities. However, 20% of institutions at this level had no GMO at the time of the Maternal and Neonatal Health Services Assessment, and 30% had only one in post. Furthermore, over 30% of secondary referral facilities did not have a Nurse Anaesthetist at post, which precluded offering caesarean sections in those institutions (Witter et al 2011).

HRH outputs from specialist training institutions decreased as there was a shortage of lecturers and tutors during the socio-economic crisis. Recruitment was difficult and vacancies were increasing at a very high rate (National Health Strategy for Zimbabwe, 2009-2013, Dal Poz et al., 2007). The option of increasing training output to reduce vacant posts was not feasible because training new nurses, doctors, midwives and allied health professionals takes time that many fragile states cannot afford

(MacKinnon & MacLaren, 2012). The HSB annual report (2011) also notes that this option could not be pursued because out of 257 nurse tutors, only 141 posts were occupied. Nurse training schools were therefore operating with inadequate staff and compromising the quality of performance.

The Access to Health Care Services Study (2007) noted that many vacancies remained unfilled at the district hospital level, with junior personnel standing in for senior professional cadres. MacKinnon et al (2012), report that the exodus of health workers during the crisis in Zimbabwe caused an inversely proportional relationship between the remaining available health workers and the increased workloads in public sector health facilities. The work overload occurred at the same time as incomes were declining, which meant the increased workload for junior personnel was going unrewarded. Witter et al. (2011) established that there was an acute shortage of specialists, including doctors, midwives and specialist nurses at a second level referral hospital in Zimbabwe. Although the norm is that 60% of nurses should have qualifications in midwifery, in this hospital the actual staffing levels were far below that. There was no paediatrician, no obstetrician, and only one doctor and one surgeon. The last time they had a Zimbabwean specialist was over 20 years ago.

The Zimbabwe HRH Profile (2009), reports that at the peak of the economic depression, the MoHCW lost 3,588 staff through resignation. The common reasons for the resignations were poorer working conditions and earning opportunities, increased workloads which contributed to demotivation, shortages of key supplies, the absence of senior staff to supervise junior staff, shortages of personal and institutional accommodation, inadequate transport for administrative supervision purposes as well as transport to and from work for staff (Zimbabwe National Health Strategy, 1997-2007; National Health Strategy for Zimbabwe, 2009-2013; HSB Annual Report, 2010; HSB Strategic Plan, 2011-2014; Mapanga & Mapanga, 2000; Mudyarabikwa & Mbengwa, 2006; Lipinge et al., 2009; Chimbari et al., 2008; Nyazema et al., 2003; Mutizwa-Mangiza 1998; Crush & Tevera 2010; Chikanda, 2005).

The health system was failing to recruit critical PHC personnel and the high vacancy rate created an internal labour market across the entire health sector but with devastating consequences for the public health sector. As the attrition of HRH in the health sector reached critical levels, a particular pattern in vacancies emerged. Initially, HRH, in particular the higher cadres, would move from the public and private sector to regional or international destinations. The private sector, which had comparatively better conditions of service, would then recruit from the public sector to fill their vacancies. As vacancies for senior staff amassed in the public sector, experienced staff in underserved areas would be moved to fill in the vacant posts in large, mostly urban facilities leaving underserved areas with unfilled posts. According to Gupta and Dal Poz (2009), Zimbabwe had the youngest facility-based workforce, with one quarter of health workers and half of physicians aged under 30 years which reflects a huge deficit in experience among providers of health care. 95% of health care providers participated in the survey, which implies that the internal labour market was creating imbalance in the levels of experienced staff in the public sector.

The Maternal and Neonatal Roadmap (2007 -2015: 14) asserts that more than two thirds of the population lives in rural areas but nearly two thirds of the national HRH establishment posts are in urban areas. This is further accentuated by a skewed rural-urban disparity in vacant posts. The HRH

situational analysis of 2008 acknowledged that there were high vacancy levels in management positions and that the health workers that were being promoted were not adequately trained in management skills. The situation analysis was conducted in all of the public sector facilities.

Distribution of HRH has remained a recurrent challenge since independence, initially due to the phenomenal expansion of the health sector and secondarily due to a lack of funding to the health sector in the years of economic structural adjustment 1991 -1997(Mutizwa-Mangiza,1998, Sikhosana, 2005). During the adjustment years, a freeze on new posts was introduced and through the public sector rationalisation initiative, retrenchment of excess manpower was adopted across the public service. However, no HRH were retrenched as the brain drain had already started in the post adjustment period and accelerated in 2000 (Mutizwa-Mangiza, 1998). Sikhosana (2005) asserts that when the Zimbabwe government implemented the civil sector reforms which were necessitated by the Economic Structural Adjustment Programme (ESAP), the MoHCW was compelled to retrench 25% of staff in the clerical and administrative areas of the service. At the time of the civil service reforms in 1994 (phase one) and 1996 (phase 2), the MoHCW records showed that the total number of posts for medical doctors of all grades was 1562, of which only 703(45%) were filled. The total for all grades of nurses was 12013 of which 4523 (35%) were occupied. When the rationalisation of posts occurred in 1994 and 1996, the attrition rate for nurses in the public sector was 11% per annum (Mutizwa-Mangiza, 1998; Sikhosana, 2005; National Health Strategy, 1997-2007).

The distribution of critical HRH has not improved and continued to worsen in subsequent years. December 2009 vacancy rates are depicted in Table 1 below.

Table 1: Selected rates for critical Health professionals as at December 2009

Critical Category	Percentage %
Radiographer	75%
X-Ray Operator	54%
Medical Laboratory Scientist/ Technologist	59%
Analytical Chemist	90%
Pharmacist	67%
Physio/Speech/Occupational Therapist	49%
Environmental Health Technician	60%
Clinical Officer	56%
Nurse Tutor	71%
Government Medical Officer	62%
Head of Medical Department & Consultant (Specialist)	73%

Source: MoHCW Zimbabwe HRH situational analysis Report 2008 Mbengwa

Distribution of HRH remains a challenge, suggesting the need for differentiated policies in relation to rural areas, especially for doctors and specialists. The HSB notes that the distribution of health workers still falls below the WHO recommended ratio of 2.3 health workers per 1000 population. Zimbabwe's estimated ratio is 1.23 health workers per 1000 population.

Witter et al. (2011) observe that in 2010, existing data showed that doctors and other specialists were not evenly distributed. In some provinces, e.g. Masvingo, Midlands, Manicaland and Mashonaland Central, there were not enough doctors to provide more complex care, and only three provinces (Harare, Bulawayo and Matabeleland South) could provide cover in the event of all deliveries taking place in health facilities. For midwives and nurses, there appear to be adequate numbers but the merger of categories (nurses and midwives) means that assessing competence in obstetric care is hard and that is likely to be shortages of skills for existing staff. Table 2 depicts the distribution of HRH by province (Witter et al., 2011).

Table 2: Delivery workload relative to population and skilled staff

Region	Deliveries			Births		
	/100,000 population	/skilled health worker	/ Doctor	/100000 population	/skilled health worker	/ Doctor
Bulawayo	1,785.68	3.86	60.39	2,020.00	4.37	68.31
Harare	2,201.89	6.87	92.04	2,637.00	8.22	110.23
Manicaland	1,916.59	19.66	1,138.10	3,178.42	32.61	1,887.39
Mash Central	1,665.45	14.05	1,036.15	3,240.18	27.33	2,015.85
Mash East	1,788.83	15.90	822.66	2,986.36	26.54	1,373.39
Mash West	1,813.08	17.44	730.67	3,296.51	31.71	1,328.49
Masvingo	2,239.04	18.19	1,737.81	2,977.45	24.19	2,310.92
Mat North	1,972.13	13.81	885.40	3,001.73	21.01	1,347.63
Mat South	2,094.49	13.50	621.73	2,925.26	18.86	868.34
Midlands	2,553.20	17.49	1,299.22	3,946.22	27.02	2,008.06
TOTAL	2,024.89	12.15	313.14	3,074.12	18.45	475.40

Source: Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for Human Resources for Health (HRH): Zimbabwe case study (Witter et al., 2011)

The workload for health workers is a major problem that requires immediate attention if Zimbabwe is to meet the many commitments that it is signatory to. A case study of Zimbabwe on HRH

challenges carried out in 2010 provided useful insights into staffing and service provision in public sector health facilities (Witter et al, 2011). This found:

1. Staffing norms have not been adjusted since the 1980s, despite programme expansion and population growth. The MoHCW and HSB recognise that this is overdue and is planning to revise it using the WHO workload model. However, it is hard to justify this exercise when existing positions remain vacant.
2. It is difficult to transfer staff and there has been a hiring freeze since mid-2010, so even vacant existing posts cannot be filled (except with permission from the Ministry of Finance, which takes 6-7 months to obtain).
3. Maldistribution of health workers is also a problem, reflecting poorer working conditions and earning opportunities. A rural allowance used to exist but was considered too low to be effective (25% of a small salary).
4. Staff are often overloaded, which contributes to demotivation.
5. Staff have poor personal and working conditions e.g. a lack of staff accommodation, lack of transport to work, dirty wards, lack of staff amenities, and no running water.
6. Shortages of key equipment and supplies e.g. blood, undermines their professional self-respect and ability to offer a reasonable quality of care
7. The lack of specialists denies remaining staff the opportunity to learn and improve their skills, while trainees mention the absence of senior staff to supervise them.
8. A result-based management system exists in theory, based on annual targets and appraisals, but the system is seen as cumbersome and the increments to reward good performance are too minimal to motivate (Witter et al., 2011).

Remuneration allowances, private practice and systems of promotion

Remuneration has been a bone of contention among health workers for a long time in Zimbabwe. Salaries and living standards had been declining since the late 1980s culminating in the adoption of ESAP in 1990 to realign the economy. The World Bank (WB) estimated that the real value of civil servants' salaries in Zimbabwe declined by more than 30% between 1991 and 1995. Doctors went on numerous strikes in 1988, 1989, 1994 and 1996, as did nurses in 1981, 1990 and 1996. In 1993, laboratory technicians and radiographers also went on strike (Mutizwa-Mangiza, 1998). These strikes were a culmination of grievances with declining living standards and conditions of service. The approach adopted by the government of Zimbabwe and the MoHCW in resolving the remuneration and conditions of service challenges faced by health workers was piecemeal and merely scratched the surface of a very complex problem (Mutizwa- Mangiza, 1998; Sikhosana, 2005). Starting in 1990, government-employed consultants were allowed to practise privately for two afternoons per week after obtaining permission from the Secretary for Health. All middle level doctors, heads of health institutions, and government-employed dentists were given a professional allowance in lieu of income from private practice. This initiative excluded nurses or other professional categories of nurses which would in the long term cause problems across the entire health sector. The remuneration structure in the MoHCW became distorted as doctors' and nurses' salaries were

reviewed more frequently than those of other groups who did not have patronage or high social status to back their cases (Mutizwa-Mangiza, 1998).

The level of salaries in the public sector is universally acknowledged to be too low – below the consumption poverty line for an average family. A qualified midwife earns \$300 per month in the public sector (up to \$400 including all allowances), but can get \$1,000 per month in private and municipal facilities. The retention allowance for public sector health workers is also low - \$70 per nurse – and is sometimes delayed. In addition, this is not paid to the non-professional grades, which leads to demotivation. The retention allowance, currently funded by the Global Fund, is also reducing by 25% each year and is due to phase out in 2013 (Witter et al., 2011; MacKinon et al., 2012). This is the reason why the migration from the public sector to the private sector cannot be stemmed. Over 80% of the HRH who leave the public sector to go to competing organisations left due to dissatisfaction with conditions of service in the public sector rather than with the profession *per se* (National Health Strategy, 1997-2007; Mutizwa-Mangiza, 1998).

There are perceptions that nurses and other professional categories are not as important in health service delivery in the public health sector. There have not been any attempts to consider nurses and other professional categories as being able to provide leadership in health delivery. Even the rules regarding private practice are not sensitive to the other professional categories outside of doctors. Nurses are not allowed to practice privately on their own. They would need to team up with a medical doctor in order to go into private practice. If nurses or other health workers practised privately, it was insignificant and did not merit comment from the MoHCW unless some serious scandal or accident occurred as a result of such a private practice (National Health Strategy, 1997-2007; Mutizwa-Mangiza, 1998).

The medical profession is the most dominant profession in the MoHCW both in terms of recognition, remuneration and general prospects for promotion. The Minister, Deputy Minister, Secretary for Health, Principal Medical Director and the Director of Maternal and Child Health are always medical doctors. All the other functional heads, e.g. the Director of Pharmaceutical Services and the Director of Nursing Services, report to the Principal Medical Director. From 1987 to 1991, even the Director of Health Manpower and Training was a medical doctor. This was a source of great dissatisfaction for other professionals who felt that their contribution was not appreciated and their education and experience were not given due weight. In addition, this entrenched dominance of the medical profession meant that for other professional categories, their aspirations for promotion ended within their career paths and not beyond. For example, a nurse would aspire to be a Principal Nursing Officer (PNO), District Nursing Officer (DNO), Director of Nursing Services, Nurse Training Administration Officer or a Senior Nursing Officer in a programmatic area (e.g. Expanded Programme for Immunisation (EPI), Mental Health etc.). This would also be the case for environmental health professionals, and other categories e.g. pharmacists. The career structure for nurses and doctors, in particular, has several promotional levels, although the nursing career structure has limited positions at each of the higher levels (Mutizwa- Mangiza, 1998; HSB Annual Report, 2011).

To work in private practice or do locum work, HRH were supposed to get permission to do so. However, during the crisis managers often did not know to what extent their staff were working

elsewhere. Until 1990, government health workers could not legally practise their profession privately, even in off-duty hours. By 1986, the Public Service Commission and the MOHCW were aware that many full-time government consultants were practising medicine privately but no action was taken (Mutizwa-Mangiza, 1998). Gupta and Dal Poz (2009) found that 41% of physicians, 7% of nurses and 10% of midwives reported dual employment, which is a reflection of the health system's inability to sufficiently compensate staff. However, some underserved areas offered limited opportunities for private practice, meaning that health workers in these areas are once again disadvantaged. Those working for local authorities and mission facilities are fortunate because they receive top-up payments and therefore may be less motivated to pursue private practice or locum work. However, the poor local authorities in rural areas do not have the resources to give attractive incentives, which make health workers look for other alternatives of making money outside the health sector thereby compromising service delivery (Chimbari, et al., 2008).

Job security and training opportunities

The public health sector has in the past been associated with job security, opportunities for career advancement and further training compared to other sectors like private, industrial, mission and local authority providers. The government offered better opportunities for further training for some professional categories. The training programmes were underpinned by clear policies as provided in the Zimbabwe Public Service National Training Policy (2002). This policy then informed the MoHCW Manpower Development Plan of 2003. This constituted a very key incentive and retention strategy for the public health sector, which in recent times has lost its allure due to interference from entities with no appreciation of the health sector (Mutizwa-Mangiza, 1998).

The MoHCW caters for the Basic Training Programmes and the Post-Basic Training Programmes in the various health care and medical specialisations. There are also opportunities for in-service training and attending symposiums/workshops, which are critical for health workers' continuing professional development. There are also Sponsored Training Programmes, usually for managerial staff, to prepare them for new responsibilities in the health sector (Manpower Development Plan 2003, HSB annual report 2010). The MoHCW also supports health workers who opt for Personal Development Programmes. Personal Development Programmes are related to individual health workers' personal ambitions and can be sponsored in line with one's duties. The Ministry encourages staff to engage in self-development efforts and is empowered to give support financially if members engage in studies that relate to their substantive duties. For all of these training programmes, the MoHCW provides support for the trainees by ensuring that they do not lose their salary benefits during training. These training programmes cater for many professional categories in the MoHCW and offer opportunities for career advancement, although the chances were reduced for most HRH belonging to larger categories such as nursing (Mutizwa- Mangiza, 1998).

Other forms of training are offered at senior and middle management level to equip HRH with specialised professional development training. Medical and Allied Staff is afforded opportunities for post-basic specialist training e.g. the Master of Medicine programmes. The Administrative Group also require management development programmes as well as some specific skills in their line of

work. Examples of training programmes available for this group include the Management Development Programme for Administrative Officers (ESAMI or other series) and Public Service Regulations (Mutizwa-Mangiza 1998; Manpower Development Plan, 2003; National Health Strategy, 1997-2007; National Health Strategy 2009-2014)

While the MoHCW offers opportunities for career advancement for most professional categories, these opportunities are skewed in favour of the medical profession. The medical profession had the best opportunities for both further training and career advancement. Any doctor who wanted to specialize in an area of critical shortage could do so almost immediately, while the rest of could embark on further training after serving two years in the less desirable rural areas, although well connected individuals did not have to endure this (Mutizwa-Mangiza, 1998). Most health workers found the selection process for further training, particularly overseas, lacking transparency. Nurses who underwent basic training found the allowances offered quite demeaning, leading to dissatisfaction. The taxation of these allowances also was a demotivating factor and the remuneration overall was a mockery of the effort involved. It is not surprising that these are the most likely to leave for the private sector, municipal providers or for regional or overseas engagements. The approach to resolving grievances of health workers has been ad hoc and reactive (Lin, et al. 2011).

Policy responses: recruitment, remuneration, retention incentives and performance management

Recruitment

Human resources planning and management in the health sector in Zimbabwe was the responsibility of the Public Service Commission (PSC) and MoHCW. Until the establishment of the Health Services Board (HSB) in 2005, the PSC was responsible for all HRH, with the MoHCW merely supervising the HRH policies on behalf of the PSC. The PSC handled recruitment, remuneration, retention allowances and other issues related to HRH welfare. The MoHCW was responsible for overseeing implementation and monitoring of technical policies for health care delivery. The Presidential Review Commission into the Health Sector (1999) recommended that there be a commission to manage the health system in its entirety, as opposed to the then existing fragmented and tenuous system where some components of the system were managed by the Ministry of the Public Service (Sikhosana, 2005). The Review Commission found that the conditions of service for HRH had plummeted since the early 1990s, resulting in debilitating attrition of HRH. The Review Commission observed that the PSC was not the best authority to superintend the MoHCW's human resource policies because of its cumbersome rules and regulations (National Health Strategy, 1997-2007).

The HSB came into being because of this recommendation, although it became a board as opposed to a commission as recommended by the Review Commission. There are views that suggest that the departure from the recommendations of the 1999 Review Commission of having a board as opposed to a commission, whittled down the prospects of autonomy of the HSB. It is noted that the HSB still has to report to the MoHCW and hence is subject to executive authority, thus rendering it less effective. Section 7(1) (a) of the Health Service Act which stipulates that, *'the Board shall report to*

the Minister as occasion requires and shall, within three months after the 31st December in that year, submit to the Minister, an annual report dealing with all the proceedings and activities of the Board during the financial year', makes the HSB an appendage of the MoHCW. This is confirmed by the Health Service Act (Chapter 15:16, Part II, Section IV) which outlines the functions of the Board, which it exercises in consultation with the Minister. Whereas a commission would have severed the interference of the Public Service Commission in HRH issues, the adoption of the board as the management entity of the health services, but still reporting to the minister served to maintain the status quo as this caption from the HSB manual (2012) attests:

'The Board has partially delegated the responsibility of coordinating the human resource management within the Public Health Service. Consequently, all communication to the HSB are to be channelled through the secretary of the MoHCW and Hospital management boards.'

One of the key responsibilities of the HSB was recruitment and deployment, creating grades in health services and fixing conditions of service to HRH in consultation with the MoHCW. In short, the HSB took over the responsibilities that were once the preserve of the PSC. The recommendations of the Presidential Review Commission into the Health Sector (1999) have not been implemented in their entirety. There has been selective adoption and implementation of the recommendations and the major confounding factors include lack of funding, bureaucratic red tape and lack of HRH planning capacity caused by the brain drain (Sikhosana, 2005). Other unresolved issues, which are critical determinants of the HSB's future effectiveness, include the reporting structure and responsibilities, the cumbersome process of submitting vacant posts to the Ministry of Finance (MoF) and the determination of the MoHCW staff establishment (*authorised positions needed in the ministry*) by the PSC.(Sub-committee on health delivery system in Zimbabwe, 2008; HSB Annual Report, 2012).

On appointment, the HSB was faced with a situation where HRH expenditure was in perpetual decline. HRH expenditure fell from 2005 to 2007, with a complete collapse in human resource spending in 2008, when human resources spending accounted for 0.3 percent of the public health budget (Osika et al., 2010; Witter et al., 2011). In the crisis years there was very little financial capacity in government for the HSB to implement policies to fulfil its mandate and most key decisions were put on hold. As of December 2007, the HSB secretariat had only 32 posts of its approved establishment filled. One of the key unfilled posts was that of Director of Legal Services a position considered critical given the work ahead for the HSB (HSB annual report, 2007). As of 31 December 2010, the HSB had only 64 out of 74 posts filled but again there were three resignations by the Deputy Director of Legal Affairs, the Deputy Director for Conditions of Service and Industrial Relations and the Principal Internal Auditor (HSB Annual report, 2011).

The recruitment of expatriate HRH to alleviate the shortage of critical specialist skills was adopted as a way of resolving the health worker attrition challenge. However, the shrinking GDP as a result of the economic crisis meant that recruiting expatriates would be very difficult or would yield the least qualified specialists in a situation where the most experienced lower level HRH were leaving their posts. The engagement of expatriates was difficult due to declining HRH expenditure. As a result, the

expatriates recruited between 2001 and 2011 were largely from Cuba, through the Zimbabwe-Cuba bilateral agreement. In 2011, more expatriates were hired, mainly from China, by the HSB (HSB 2011: 32-33). Another constraint with regards to the foreign recruitment of HRH is ascertaining the compatibility of qualifications with national qualification frameworks. This is often a costly exercise both in terms of financial resources and time.

One of the recruitment dimensions which the HSB failed to wrestle from the PSC is how MoHCW staffing levels are determined. This was last reviewed in 1983 despite the many changes in the population structure, both in terms of size and geographical distribution. Land reforms caused a phenomenal change in the distribution of the population, yet the staffing of health facilities remains the same (Sikhosana, 2005; HSB Annual Report 2011; Mudyarabikwa & Mbengwa, 2006).

In October 2008, at the peak of the health sector crisis, a sub-committee was created to critically appraise the Health Delivery System in the country, with the intention of formulating concrete measures that addressed the challenges being faced. The committee was to be chaired by the Secretary for Health and Child Welfare and members included the Secretary for Economic Development Secretary for Finance, Secretary for Information and Publicity, Secretary for Higher and Tertiary Education, Secretary for Water Resources and Infrastructural Development; and Secretary for Energy and Power Development (Policy framework For Revamping the Health Sector Delivery system in Zimbabwe, 2008). Some of the HRH policy recommendations of this sub-committee were the recruitment of retired personnel, using medical staff from the uniformed forces as a stop-gap and enhancing HRH training programmes. The committee also recommended that the private sector complement government efforts by providing transport, housing and other allowances (e.g. uniforms) to medical staff. However, there was no mention from the sub-committee on the critical subject of how these policy positions were going to be funded. Most of these policies were never implemented and the HSB is still pursuing some of them with little success (HSB annual Report; 2010; 2011). The only policies that have been implemented are the re-engagement of cadres who have retired, to continue in the service and using medical staff from the uniformed forces in the public health sector.

Retention incentives and training

In an effort to ensure that the PHC model continued to be implemented in underserved areas the MoHCW responded by introducing a new nursing cadre, the Primary Care Nurse (PCN), in 2005. The PCN was trained specifically to work in rural health centres. The introduction of the PCN was an attempt to ensure a stable nursing cadre for rural areas, who, by virtue of their training, would not be attractive to the international labour market (Maternal and Neonatal Roadmap 2009-2015; HRH policy 2010). In addition, a policy to recruit locals at nursing schools was adopted on the assumption that on completion of training the graduates would work in their locality. This was meant to ensure that there was a qualified nurse at each rural health centre. Unfortunately, this did not mitigate the attrition of nurses at rural health centres due to bottlenecks in the recruitment procedures. The PCN posts remain outstanding since inception. All PCNs are appointed against nursing posts. This means that there has been no regularisation of the PCN cadre in the general establishment regulations. The

implication of this is that PCNs will remain PCNs because there is no professional progression to upgrade to RGN. The training of PCNs has since been stopped because of an improvement in availability of RGNs.

Fellowship and scholarship programmes, as well as advanced training programmes, were introduced in 2007 to enhance the capacity of the health professionals to provide services (Chikanda, 2010). Cadetship posts were also introduced to support the training of medicine, dentistry and pharmacy students, and in 2007, 18 students were supported (HSB annual report, 2007). The cadetship programme is a government programme which finances training if the student agrees to commit themselves to work in the public sector for a period equivalent to the length of their training post qualification. It also allows the beneficiary to spend time in the workplace during their vacations to gain on-the-job experience (Chimbari, 2008; HSB annual report, 2007). These programmes were also meant to reduce the migration of nurses who left to further their studies, however, health workers were not happy with these initiatives. One reason could be that the initiatives were introduced at a time when the HRH situation had deteriorated so drastically that it would have been difficult to make any impact at all.

In 2009, after the formation of the inclusive government, initiatives to revitalise the HRH retention scheme were adopted with the support of development partners. From the onset, the HSB and MoHCW were made aware that the retention scheme was a short term intervention which should see the government of Zimbabwe taking on the responsibility for paying HRH in the long term. This means in 2013, the retention scheme will cease and the government will have to put in place attractive salaries to retain HRH (HSB Annual Report, 2011).

The MoHCW and development partners are administering the short term retention scheme. The introduction to this short term retention policy states that the retention scheme is an effort to retain health workers in the public health sector in the harsh economic environment. Eligibility criteria was stated as *'all full time employees in MoHCW including health workers in mission and council facilities, who were reporting for duty, and actually working during the period under funding which will be specified by the funding partner'*.

The scheme involves topping up government salaries with retention payments. In March 2009, the government and its partners revised the retention scheme to include MoCHW grades C5 and above only (HSB Human Resources Retention Policy, 2010). There seems to be evidence to suggest that the retention scheme, currently managed by Crown Agents, brought some stability to the public health sector in the medium term (HSB Human Resources Retention Policy, 2010). The number of resignations in 2009 dropped to 84% (567) of the previous year, although this may have also been a result of dollarization (Africa Health Workforce Observatory, 2009; Zimbabwe Health System Assessment, 2010; Witter et al., 2011).

The top-up payments, funded by partners, were higher than base salaries for some grades. For example, a District Nursing Officer in 2008 received \$250 as monthly salary and \$280 as retention payment. The differences for higher grades were even greater (Witter et al., 2011). These differences have affected HRH morale and elicited negative responses.

Remuneration and allowances

Remuneration of health workers has always been a problem that the government had failed to deal with. In 1994, a job evaluation of the whole civil service revealed that government salaries were lagging behind those of parastatals by 84% and those of the private sector by 172%. Salaries were subsequently increased by 60%, to be awarded over a three year period. This was not done and led to a strike in 1996, never to be effected again (Mutizwa-Mangiza, 1998).

Salary reviews were introduced to cushion health professionals from the effects of inflation and the high cost of living and not as a deliberate policy initiative to compensate HRH fairly. Salaries and allowances were reviewed three times in January, May and September in 2007 indicating the phenomenal rate at which real incomes were being eroded by hyperinflation (HSB Annual Report, 2007). In January 2007, medical allowances were raised from 20% to 300% of basic pay. These were subsequently reviewed downwards to 70% of basic pay in May 2007. On-call allowances were also raised from 24.5% to 200% of basic pay in January 2007. These were subsequently reviewed downwards to 135% of basic pay in May 2007. Prior to May 2007, there was an average 33% salary differential between the Health Service and the General Civil Service in recognition of the uniqueness of the health sector (HSB Annual Report, 2007; Chimbari, 2008).

The policy to harmonise salaries and allowances in the public service beginning 1 May 2007 led to a lower salary being awarded to the health sector compared to the rest of the civil service. This became a source of concern among health workers and fed into the already existing disenchantment with working conditions. Starting in January 2007, nurses were entitled to an allowance when they received their post- basic qualifications e.g. midwifery. The allowance was to be equivalent to 67.5% of their basic salary, according to the grade for each qualification, but was not to be paid concurrently with an on-call allowance (Chimbari, 2008). The advanced post basic training for nurses' fellowship programmes and the periodic salary reviews did not stem the "medical brain drain".

Other measures were introduced at the height of the crisis to manage the movement of workers from rural to urban areas. These included a rural allowance (10% of basic salary) for remote areas, support for the relocation of workers' spouses and the provision of suitable accommodation (Chimbari, 2008). All of these initiatives failed, perhaps due to the hyperinflation characterising the crisis period.

In 2009, efforts to revitalise all aspects of the health sector were initiated including improvements in remuneration allowances and other non-financial incentives for the health work force. In 2011, the Ministry of Finance made two salary reviews in an effort to raise the health worker salaries. The first review was in January 2011 and raised basic salaries by 9.5% across the board. A second review in July 2011 further raised basic salaries by another 8%. Despite these efforts, salaries remain very low and the salary differentials between grades remain very small (HSB Annual Report, 2011).

Allowances for housing and transport were also given consideration. The housing allowance was improved by 367% in January 2011 and by a further 55% in July 2011. Despite the seemingly huge percentage increases, the resultant allowances for housing remained way below the market rates for rentals.

Free government buses operated by the Public Service Commission are available to transport health workers to and from work in major cities but not in rural areas. There is also a transport purchase fund introduced in 2007 managed by the Central Mechanical and Equipment Department (CMED), which allows health workers to access vehicle loans. In 2011, the government introduced the civil service Housing Loan Scheme under the management of the Ministry of National Housing and Social Amenities. Two hundred and sixty eight health workers benefited from the housing initiative. A duty free vehicle importation scheme is also in place for some grades and 143 health workers benefited from this in 2011 (HSB Annual Report, 2011).

Other retention mechanisms

A raft of retention mechanisms were introduced in the years before, during and after the crisis to ensure the equitable distribution of health workers at facilities, particularly in underserved locations of the country. All civil servants based in rural areas were awarded a rural allowance in 1996 (Mutizwa-Mangiza, 1998). However, this did not achieve the desired retention of HRH. Bonding of newly qualified nurses was introduced in 1997 to ensure retention of health workers. All nurses who started their training were bonded by the government for 3 years, a period equivalent to duration of training (Chikanda, 2010). The bonding policy was further tightened in 2007 to include the withholding of certificates and diplomas from newly qualified nurses until they completed the bonding period. This implied that bonding was not achieving the intended outcome with regards retention.

Performance management

The notion of incentives as defined by Fritzen (2007), as including clear career paths and promotion opportunities, effective and impartial systems for linking individual performance to the goals and functions of the organization over and above the official salary, was adopted by the Zimbabwe government in 1995. The notion behind this performance management initiative was to increase salaries, bonuses, promotion and advancement within grades of high performers based on a systematic, participatory and transparent process (Mutizwa-Mangiza, 1998). This exercise was spearheaded by the PSC but the performance management initiative did not work. Some of the underlying causes of its failure were that there was a lot of resistance to this exercise within the MoHCW and the results of the initiative were never put to good use (Chikanda, 2010, MoHCW HRH strategic plan, 2010). The performance appraisal system created human resource management problems and there was little capacity for HRH planning and management among managers. In 1995, an audit by the MoHCW found that individual performance appraisals for health workers were often not completed appropriately and most supervisors gave good reports even where bad ones were called for (Mutizwa-Mangiza, 1998). The Auditor General's report of 1995 concurred that the

performance appraisal system was 'useless', as even the worst doctors were given very good reports.

The audit also established that the idea of performance-related promotion and remuneration in a context of crippling shortages of staff in all professional categories and resources hardly represented an optimum working environment in which set objectives could be achieved. Linking salary increments, promotions, and bonuses to performance could only be feasible for most health workers once acceptable instruments for doing so were in place. The nurse supervisors were always too busy themselves because of staff shortages, and would not therefore effectively teach, supervise, and evaluate their juniors (Mutizwa-Mangiza, 1998).

Decreasing capacity to fund the performance appraisal system in the years following the spending cuts imposed by the economic structural adjustment programme was another setback (Mutizwa-Mangiza, 1998). The socioeconomic crisis, starting around 1997, also saw severe under-funding of almost all government programming, which also curtailed the proper administration of the performance appraisal initiative. One major criticism of the performance appraisal system of 1995 was that its objectives were too broad and unrelated to the health sector. An area of serious concern was the aspect of workload and how this could be dealt with in the performance appraisal process. The general feeling among health workers was that the MoHCW would have to address the issue of consultants' employment terms, stating the minimum number of hours they have to work, the distribution of workload between them and their juniors, and the minimum level of supervision required for junior doctors.

In 2005, the government admitted that the performance management system had failed and adopted the Results Based Management system (RBM). The RBM was introduced as part of government-wide public sector reforms that began being implemented in 1997 but the end date is unknown.

The RBM is coordinated by the HSB. A Deputy Director of Manpower Planning was appointed to spearhead this process in the public health sector institutions. Starting in 2012, the RBM Personnel Performance System is to be fully implemented in the MoHCW annual performance cycle. The success of RBM will depend on the commitment of government to fund the process and given the current economic outlook, it is going to be very difficult to make it work (HSB Annual Report, 2011).

There has been progress in the rolling out of the RBM performance management system by the HSB. In its annual report (2011) the HSB notes that senior managers have been trained on coming up with institutional strategic plans using the Integrated Result Based Management principles. All Directors, Health Service Board Secretariat, Deputy Directors and equivalent grades were trained the RBM appraisal system in the last quarter of 2011, so the Personnel Performance System could be effectively implemented in 2012. What this means is that there has not been a functional performance management system in the MoHCW since independence, which probably accounts for the widespread disenchantment that HRH have displayed in their relationship with the public sector. There is no indication that the RBM will fare any better as all the weaknesses cited in the earlier performance management system seem to be inherent in the RBM. RBM is a civil service-wide

personnel performance management system just like the performance management system it is replacing. The PSC is the coordinating institution and the HSB's role is to ensure that the system is fully implemented in MoHCW; however this responsibility is not included in the mandate of the HSB.

Effects and effectiveness of the policies

Systematic evaluation of the effects of policies that have been implemented over time is difficult to access. However, copious reference to evaluations of policies by the MoHCW, HSB or MoHCW and development partners, either as part of wider health system assessments or specific policy evaluation has been noted. Annual reports of the HSB provide snippets on effectiveness of and or challenges of implementing HRH policies. There has been independent academic research around the effectiveness and impact of some policies which is readily available vis a vis government initiated evaluations.

The creation of the HSB was seen as a master stroke that would lead to the reform of the health sector. This however was not to be because from inception, the HSB was encumbered by inadequate staff, poor financial resources and a cumbersome process that made decision making slow. The scholarship programme introduced by the HSB was not effective because inadequate financial support, allegations of corruption in the selection of beneficiaries and patronage (HSB Annual Plan, 2011). The cadetship programme to help provide a stable health workforce was not successful largely because of financial constraints. In a study of health worker incentives by Chimbari (2008), key informants observed that the cadetship scheme was a good policy but of little benefit to employees or employers in the harsh economic climate.

Several studies (Witter et al., 2011) and assessments on behalf of development partners (Wheeler, 2010; Dieleman, et al., 2012) have concluded that the short term retention scheme has begun to elicit negative reactions between the health workers receiving it and those not receiving it. There is a general feeling among those in grade C4 and below, who are either not receiving retention allowances or have been receiving retention but have been excised as part of the phased withdrawal by development partners, to view themselves as non-essential actors in the health delivery process (Witter, 2011). The selective nature of the retention scheme created human resource management problems at health facility level (HSB Annual Report, 2011; Zimbabwe Health System Assessment, 2010). The Zimbabwe Health System Assessment (2010) reports that Chipinge District Hospital experienced a staff labour strike due to the inability of staff at grades C4 or below to receive retention allowances. Three other facilities (Kawere Clinic, Marondera Provincial Hospital and Plumtree District Hospital) also reported that labour strikes had occurred, with certain grades' ineligibility for retention bonuses as one reason for the strike. Those that were getting retention allowances were disillusioned by the phased reduction of the retention allowance and the impending total cessation in 2013. This has become a serious demotivating factor for the health work force (HSB Annual Report, 2011).

On inception of the retention scheme, government and donors had agreed that health worker salaries would increase at a rate corresponding to the reduction in the retention allowance. Put simply, if the retention allowance reduction was 25%, this should have seen salaries of health

workers appreciating by a similar rate. Retention schemes need to be well thought out, supported by a robust budget and properly targeted, as they may in the medium to long term fracture work relations.

The bonding programme did not achieve intended objectives from the time of inception. The deepening of the socioeconomic crisis meant that the pull factors in destinations for migrating nurses became more attractive. In response, the bonding policy was further tightened in 2007 to include the withholding of certificates and diplomas from newly qualified nurses until they completed the bonding period. Bonding therefore only acted as a delaying mechanism but not a *fait-accompli* solution to HRH attrition. Some nurses were even prepared to forfeit their certificates as they sought opportunities, sometimes outside of the nursing field (Chikanda, 2010).

When we look at the broad national picture, indications are that the current HRH retention scheme seems to work for all other cadres within the public health sector except for medical doctors, midwives, radiologists, laboratory personnel, environmental technicians, environmental officers and pharmacists, whose vacancy rates have not changed since the inception of the retention scheme (Zimbabwe Health Worker Retention Scheme, 2011; Abt Associates, 2010). A recent evaluation has indicated that public sector vacancies for nurses have declined due to the implementation of the health worker retention scheme. A five year trend analysis by the HSB indicates that vacancies have decreased for most HRH categories, e.g. for Environmental Health Technicians (EHTs), the vacancy rate has decreased from 60% in 2007 to 51% in 2011. However, the rate for specialist doctors has risen from 74% in 2007 to 77% in 2011.

The CMED transport purchase fund has not been allocated funds since 2009 (HSB annual Report 2011). The government introduced the civil service Housing Loan Scheme under the management of the Ministry of National Housing and Social Amenities. Very few health workers benefitted so in the final analysis the policy had no effect on health worker morale. The duty free vehicle importation scheme which selectively targets some grades has also had minimal effect and has been viewed as very patronising.

The main reason why policies to retain HRH fail to achieve the desired outcomes is because they are applicable to a wide spectrum of civil service employees. The government has failed to deal with the political conundrum of singling out the health sector for special treatment, as seen in inconsistencies demonstrated by the review of salaries and allowances for health workers in July 2007. With regards rural areas, the incentives are available to every health worker and therefore do not serve the intended purpose intended (Chimbari, Madhina, and Nyamangara 2008). The other reason for HRH policy ineffectiveness is that they are designed for a specific category in the public health sector, like the harmonised retention scheme which targets grade C4 and above. Yet the health sector comprises different categories of workers who all contribute to achievement of desired health outcomes. When these workers are excluded they demonstrate their disgruntlement through strikes or reduced commitment to tasks.

Conclusions

Attracting and retaining HRH continues to pose serious challenges to the health sector in post crisis Zimbabwe. Numerous policies formulated since 1997 when the crisis began to manifest, through the crisis and up to the post crisis period, have had limited impact on the HRH crisis. Literature provides insightful explanations on lack of progress in addressing the challenges of health worker attraction and retention. Poor funding of policies is cited as a key cause of policy failure during and post-crisis. Some of the literature asserts that migration of health workers with managerial skills made it difficult to implement policies that would have helped retain health workers, especially the performance appraisals. Evaluation and monitoring of previous policies has not been a priority. New policies have been crafted because the previous one needed to be replaced, however where evaluation has been done, the findings of the evaluation seem not to have been referred to in the next policy. The rivalry between different ministries has contributed to the failure of HRH policies as other ministries argued against initiatives to make HRH conditions better. The most important outcome from this document review is that remuneration stands out as the single most important factor influencing health worker behaviour. The attrition of HRH in Zimbabwe is a complex problem that requires the formulation of strong policies, sustainable funding and greater inter-sectoral coordination in implementation of policies.

Lessons learned

- Training opportunities have become a demotivating factor as they are not perceived to be allocated on merit.
- Successful implementation of reforms require much more time for planning, informing, and consulting health workers and mobilising political support than was available in the Zimbabwean context.
- Successive policies have lacked a consultative process and the political buy-in from other ministries, hence the failure to secure funding for the implementation of many policies.
- Attrition rates have reduced following the implementation of the short term retention scheme, suggesting that incentives can work to retain skilled HRH if they are professionally managed.
- Staff numbers have been reduced through emigration to other countries and also internal migration to other sectors, though this is less well documented.
- The public sector can best improve working conditions by learning from the other sectors that are attracting HRH from the public sector.
- The phased withdrawal of the emergency retention scheme has begun to revive the brain drain. There is the need for the MoHCW to work on securing replacement funding to sustain the retention allowance quickly before the attrition regains momentum.

- There is need for intensive capacity development to ensure that the human resources function is carried out by individuals with the right competencies.
- Policies should be monitored and evaluated and the findings from such processes should be made available to a wide audience rather than to a select few.

References

1. Abt Associates 2010 Zimbabwe Health Systems Assessment, Bethesda, Maryland.
2. Africa Health Workforce Observatory (2009) Human Resources for Health Country Profile Zimbabwe. Zimbabwe Health Workforce Observatory.
3. Awases M, Gbary A, Nyoni J and Chatora R (2004) Migration of Health Professionals in Six Countries: A Synthesis Report. WHO Regional Office for Africa, Brazzaville: DRC
4. Chen L, Evans T, Anand S et al. Human resources for health: overcoming the crisis. *The Lancet* 2004; 364:1984-1990.
5. Chikanda A (2005) Medical Leave: The Exodus of Health Professionals from Zimbabwe. (in Crush. J and Tevera. D eds *Zimbabwe's Exodus: Crisis, Migration, Survival*) Southern African Migration Project: Cape Town.
6. Chimbari MJ, Madhina D, Nyamangara F, Mtandwa H and Damba V (2008) Retention incentives for health workers in Zimbabwe. EQUINET Discussion Paper 65. EQUINET: Harare; www.equinet africa.com
7. Crush. J and Tevera. D, 2010 *Zimbabwe's Exodus: Crisis, Migration, Survival* Cape Town: Southern African Migration Programme.
8. Dal Poz, M.R., Kinfu, Y., Drager, S., Kunjurnen, T. 2007. Counting health workers: definitions, data, methods and global results. Department of Human Resources for Health. World Health Organization. Available at: http://www.who.int/hrh/documents/counting_health_workers.pdf
9. Dambisya YM, Lipinge S, Loewenson R 2010 Health worker retention and migration in Africa - Implications for Sustaining Health Systems, University of Limpopo, University of Namibia, Training and Research Support Centre in EQUINET, with ECSA-HC, Mimeo, Paper produced for the African Platform for Human Resources for Health, November 2010
10. Dambisya, YM (2007) A review of non-financial incentives for health worker retention in east and southern Africa. EQUINET Discussion Paper 44: EQUINET: Harare; www.equinet africa.org/
11. de Castella. T Health workers struggle to provide care in Zimbabwe; Brain drain adds to woes of a cash-strapped health-care system (*The Lancet*)• Vol 362 • July 5, 2003 www.thelancet.com
12. Dieleman, M., Watson, M., Sisimayi, (CCORE) Impact Assessment of the Zimbabwe Health Worker Retention Scheme Final Report ,DFID Human Development Resource Centre 295358
13. EQUINET, Health Systems Trust 2005 "Equity in the distribution of health personnel in
14. European Union (2011) *What The European Union And Its Member States Do For The Zimbabwean Health Sector* Harare: European Delegation
15. GoZ 1981 Growth with Equity Harare: GoZ
16. GoZ 1999 Zimbabwe: Presidential Review Commission into the Health Sector 1999 Harare: GoZ
17. GoZ 2009 Short Term Emergency Recovery Program Harare: GoZ
18. GoZ 2009 Short Term Recovery Programme: Getting Zimbabwe Moving again Harare: GoZ
19. GoZ 2010 Medium Term Plan (2010–2015):Towards Sustainable Inclusive Growth human centered Development, Transformation and Poverty Reduction Harare: GoZ

20. GoZ 2010 Public service Payroll and Skills Audit
http://www.publicservice.gov.zw/index.php?option=com_content&view=article&id=84&Itemid=70;
21. Grindle, M. 1997 Divergent cultures? When public organizations perform well in developing countries. *World Development*, 25(4)
22. Gupta, N., and Dal Poz, M: Assessment of Human Resources for Health Using Cross-National Comparison of Facility Surveys in Six Countries. *Human Resources for Health* 2009, 7(22): 1-9.
23. HSB (2005) Pulling Together for Health: Annual Report, 2005. Harare: Health Service Board.
24. HSB (2006) Pulling Together for Health: Annual Report, 2006. Health Service Board: Harare
25. HSB 2010 Health Service Board Annual Report 2010 Harare: HSB
26. HSB 2010 Health Service Board Strategic Plan 2011-2014 Harare: HSB
27. HSB 2010 HSB Human Resources Retention Policy 2010 Harare: HSB
28. HSB 2012 Health Service Board Annual Report 2011 Harare
29. Initiatives Inc (2000) Human Resources study – conducted for the Ministry of Health and Child Welfare (Zimbabwe). Initiatives Inc: Boston, Massachusetts.
30. Initiatives Inc. (1998) Ministry of Health and Child Welfare Report of the Motivational Survey: Volume 1. Initiatives Inc.: Boston.
31. King, G. 2003 Report of SHORT term consultancy in human resources with MoH Transitional Islamic State of Afghanistan 10-28 March , London, Department for International Development, Health systems Resource Centre
32. Lin, V., Ridoutt, E, Brink, E, Hollingsworth, B. 2011 What incentives are effective in improving deployment of health workers in primary health care in Asia and the Pacific (in Jalilian, H and Sen V eds Improving Health Sector Performance : Institutions, Motivations and Incentives The Cambodia Dialogue. Singapore :Institute of Southeast Asian Studies
33. Lipinge S, et al (2009). Policies and Incentives for Health Worker Retention in East and Southern Africa: Learning from Country Research. EQUINET Discussion Paper 78 EQUINET: Harare.
34. M. Van Dormael, G. Kegels & B. Marchal M. 2005 Human Resources for Health: Confronting Complexity and Diversity Institute of Tropical Medicine, Antwerp
35. MacKinnon, J. And MacLaren, B. (2012) Human Resources for Health challenges in fragile states: Evidence from Sierra Leone, South Sudan and Zimbabwe North-South Institute
36. Mapanga, K. G. and. Mapanga, M.B. 2000 A Perspective Of Nursing In Zimbabwe(OJIN) May 2000
37. MoHCW 1981 Planning for equity in Health Harare: GoZ
38. MoHCW, 1997 Zimbabwe: National Health Strategy 1997-2007: Working for Equity and Quality in Health Harare: GoZ
39. MoHCW (1997b) Health Human Resource master plan. MOHCW, Harare: Government of Zimbabwe MoHCW 1997 Zimbabwe: National Health Profile 1997 Harare: GoZ
40. MoHCW 1998 Zimbabwe: National Health Profile 1998 Harare: GoZ
41. MoHCW 1999 Three Year Rolling Plan (1999-2001) Harare: GoZ
42. MoHCW 1999 Zimbabwe: National Health Profile 1999 Harare: GoZ
43. MoHCW 2000 Zimbabwe: National Health Profile 2000 Harare: GoZ

44. MoHCW 2001 Zimbabwe: National Health Profile 2001 Harare: GoZ
45. MoHCW 2002 Zimbabwe: National Health Profile 2002 Harare: GoZ
46. MoHCW 2004 Zimbabwe: National Health Profile 2004 Harare: GoZ
47. MoHCW 2005 Zimbabwe: National Health Profile 2005 Harare: GoZ
48. MoHCW, UNFPA, UNICEF & WHO (2005) Assessment of Maternal and Neonatal Health Services in Zimbabwe. Final Working Draft, Zimbabwe.
49. MoHCW 2006 Zimbabwe: National Health Profile 2006 Harare: GoZ
50. MoHCW 2007 The Access to Health Care Services Study Harare: GoZ
51. MoHCW 2007 Zimbabwe Maternal and Neonatal Health Roadmap 2007-2015 Harare: GoZ
52. MoHCW 2007 Zimbabwe: National Health Profile 2007 Harare: GoZ
53. MoHCW 2008 Zimbabwe HRH Situation Analysis Report-2008 Harare: GoZ
54. MoHCW 2008 Zimbabwe: National Health Profile 2008 Harare: GoZ
55. MoHCW 2009 The National Health Strategy for Zimbabwe(2009-2013): Equity and Quality in Health: People's Right Harare: GoZ
56. MoHCW, 2010 The Zimbabwe Health Sector Investment Case (2010-2012) : Accelerating progress towards the Millennium Development Goals Harare: GoZ
57. MoHCW & HSB 2010 Human Resources for Health Policy 2010-2014 Harare: MoHCW & HSB
58. MoHCW & HSB 2010 Human Resources for Health Strategic Plan 2010- 2014 Harare: MoHCW & HSB
59. MoHCW 2011 Human Resources Strategic Plan Harare: GoZ
60. Mudyarabikwa, O. and Mbengwa, A. 2006 Distribution of Health Workers in Zimbabwe: A Challenge for Equity in Health Equinett Discussion paper 4
61. Musiyambiri M 2003 An Evaluation of the Performance Appraisal System of the Ministry of Health and Child Welfare. Zimbabwe Public Administration Management Institute: Harare.
62. Mutizwa M. D and Mbengwa AG (2000) 'Human resource policies and equity in health in southern Africa', paper presented at EQUINET conference, Midrand, September 2000. EQUINET: Harare.
63. Osika, J., Altman, D., Ekbladh, L., Katz, I., Nguyen, H., Rosenfeld, J., Williamson, T., and Tapera, S. (2010) Zimbabwe Health System Assessment 2010. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.
64. Reid, M. 1994 Developing of health workforce projections and advising on health workforce norms for Cambodia. Mission Report, 16 January-11 February 1994
65. SADC 2010 The SADC Health Protocol Maputo: SADC
66. SADC-HRH (2006) Southern Africa Development Community Human Resources for Health Strategic Plan, 2006–2019. SADC: Johannesburg.
67. Sanders, D 1990 Equity in Health: Zimbabwe Nine Years On. (Journal of Social Development in Africa), 5,1, 5-22
68. Sikhosana, P. L.N. 2005 Challenges in Reforming the Health Sector in Africa 2nd edition Victoria: Trafford publishing
69. Sileap, K. And Smith, J. 1996 The Redevelopment of the Nursing Care Concept in Cambodia Health Care Delivery. Paper presented at the 2nd International Nursing Conference, Brunei Darussalam, November 1996.

70. Smith, J 2002 Human Resources and capacity building for health reconstruction/rehabilitation in Afghanistan, Mission Report 15 January-14 May 2002 Kabul Afghanistan, World Health Organisation.
71. Southern Africa," Report of regional meeting held in Johannesburg, 18-20 August 2005.
72. The Sub Committee on the Health Delivery System in Zimbabwe 2008 Policy Framework For Revamping the Health Sector Delivery system in Zimbabwe Harare: GoZ.
73. Wheeler, M 2009 Analysis of Internal Migration within and from the Ministry of Health and Child Welfare: Zimbabwe Draft Report, DFID-Human Resources Development Centre
74. WHO 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium Ouagadougou: WHO African Region
75. WHO 2009 Human Resources for Health Country Profile Zimbabwe Geneva: World Health Organisation 2010
76. WHO and MOHCW 2002 'Humanitarian Assistance and Recovery Programme,' Rapid Needs Assessment for the Health Sector in Zimbabwe. MOHCW, Harare: Government of Zimbabwe.
77. Witter, S., Chirwa, Y., Munjoma, M., Mashange, W., Ensor, T., & McPake B., 2011 Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for Human Resources for Health (HRH): Zimbabwe case study (In: McPake, B.; Witter, S.; Ensor, T.; Fustukian, S.; Newlands, D.; Martineau, T. Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for Human Resources for Health (HRH). Research paper for DFID. http://www.dfid.gov.uk/r4d/Output/189473/Default.aspx?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+R4DMaternalHealth_Docs+%28R4D+Maternal+Health+Documents%29.
78. Zimbabwe Health Service Board (2005) Health Service Board Strategic Plan: 2005–2010. Harare: Zimbabwe Health Service Board.
79. Zimbabwe Health Workforce Observatory, 2009. Human Resources for Health Country Profile. World Health Organization. Last accessed August 8, 2012. http://www.hrh-observatory.afro.who.int/images/Document_Centre/zimbabwe_hrh_country_profile.pdf