



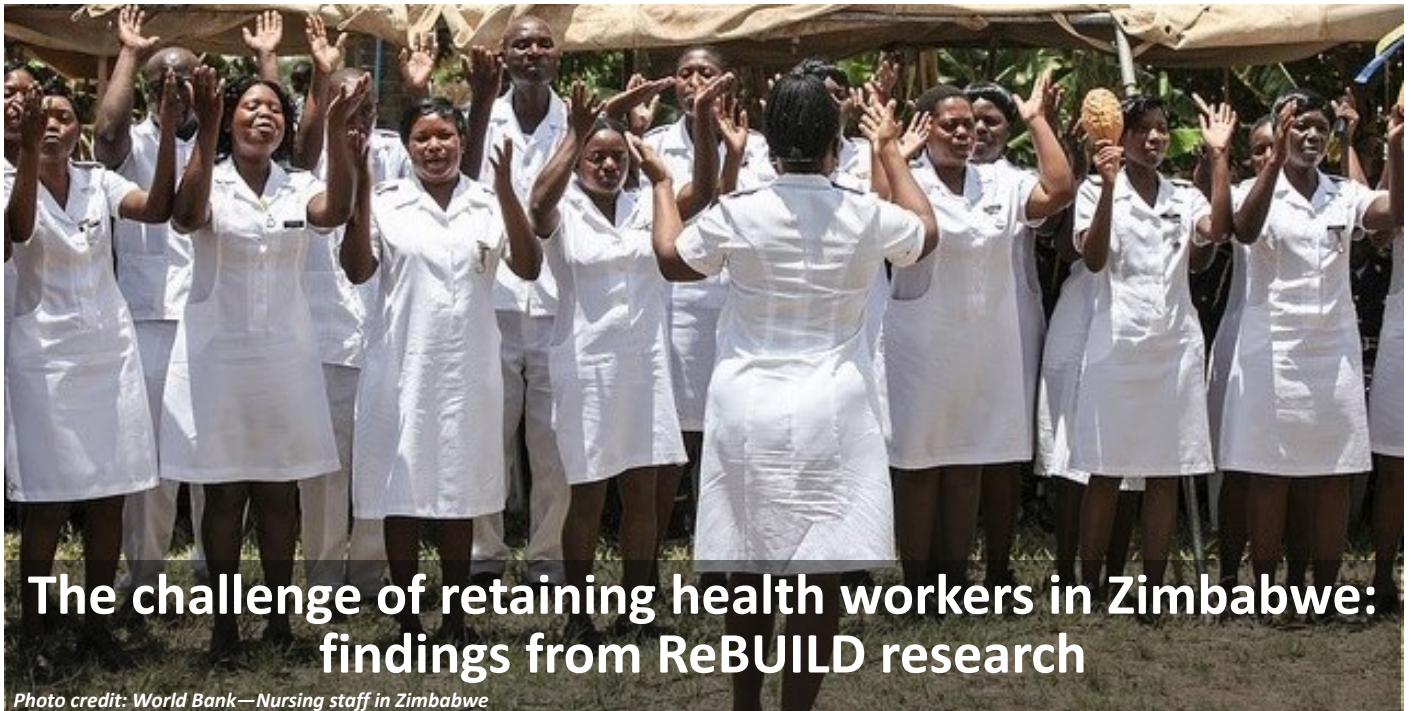
Biomedical Research
& Training Institute



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Research for stronger health systems post crisis

Briefing



The challenge of retaining health workers in Zimbabwe: findings from ReBUILD research

Photo credit: World Bank—Nursing staff in Zimbabwe

BACKGROUND: What is the ReBUILD RPC?

The ReBUILD Consortium is a 6-year research partnership funded by the UK Department for International Development (2011-17). We are working with partners in Cambodia, Sierra Leone, Uganda and Zimbabwe to explore ways to strengthen policy and practice on health financing and human resources. Additional affiliate research projects broaden the range of contexts. ReBUILD's purpose is to generate robust, good quality evidence that responds to the challenges that policy makers face.

ReBUILD in Zimbabwe

In Zimbabwe, the research is being led by the **Biomedical Research & Training Institute**. BRTI is an independent research institution working to promote better health in Zimbabwe through research and training. Core activities are to promote and support relevant, ethical research in all aspects of health, and build capacity through training for researchers to design, conduct and report on relevant health research.

The ReBUILD projects in Zimbabwe are covering three areas: (i) health financing and its effect on poor households, (ii) health worker incentives and (iii) rural posting of health workers. Gender and equity are mainstreamed through all ReBUILD's work in Zimbabwe, and will continue through a new BRTI project on gender in rural posting and deployment of health workers, funded by ReBUILD's partner RinGs initiative.

Why is ReBUILD focusing on post-crisis contexts?

In countries affected by socio-economic crisis or conflict, health systems break down and external emergency assistance is often the main source of care. As recovery begins, so should the process of rebuilding health systems. But health systems research has neglected post-crisis/post-conflict contexts and not enough is known on the effectiveness of different approaches. ReBUILD has been created to address this challenge.

ReBUILD's research on health worker incentives in post-crisis Zimbabwe

Research aim: To understand the post-crisis dynamics for human resources for health and ultimately how to reach and maintain incentives to support access to affordable, appropriate and equitable health services.

Research questions: *How has HRH policy evolved during and post-crisis? What incentives are available for health workers? What have been the implementation challenges and the effects of the incentives programmes?*

Study areas and methodology: Three contrasting districts, including rural and urban areas, looking at government, municipality/RDC, private and mission health providers. The methodology combined: document review (76 documents), analysis of routine staffing data, key-informant interviews (24 at national and district level), career histories of health workers (35 life histories), and a survey of health workers (227 doctors, nurses, midwives and EHPs).

Full details of the above methodology and the detailed findings are available in a series of research reports (see further information below). Below is a summary of the key findings and recommendations from these reports.

Key findings:

Evolution of policy

- There has been a recognition of the need for measures to improve retention of health workers since the late 1990s and a series of policy measures were introduced; however, these have not been effective and many have been reversed; one reason is failure to deal with the political conundrum of singling out the health sector for special treatment
- The Ministry of Health and Child Care has limited support from the Ministry of Finance and the Ministry of Public Service, for ensuring funds are available for HRH remuneration
- There is lack of sustained funding from government for other incentives, such as housing and vehicle schemes

Incentives and their implementation

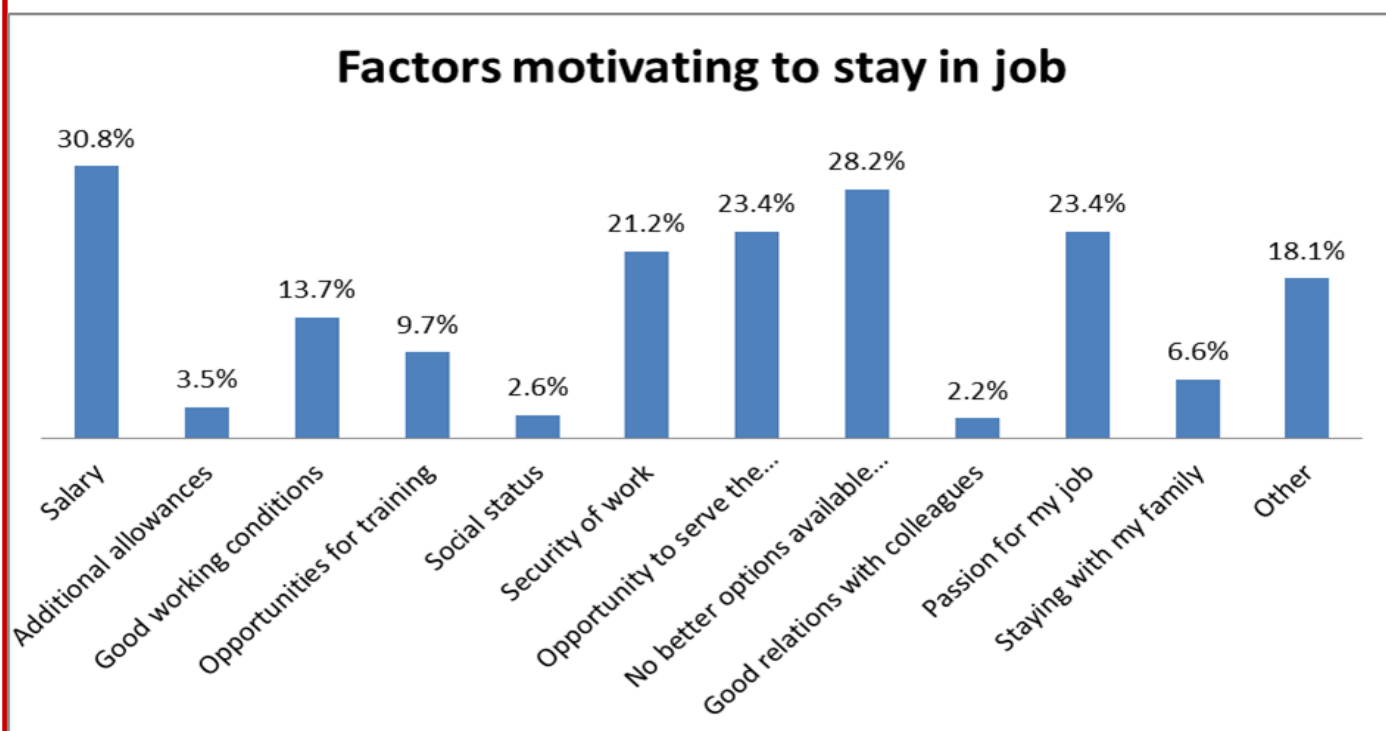
- Staff have limited awareness of different incentive schemes and how they should work
- There is preferential treatment for some professional categories in the public health sector (doctors, midwives, RGNs, SCNs, PCNs, EHTS, EHOs) versus other medical professionals
- The migration of health workers with managerial skills made it difficult to implement policies that would have helped retain health workers, e.g. performance appraisals
- The establishment list is outdated and does not reflect real staffing patterns or needs; there has also been a freezing of posts in place since 2010
- Evaluation and monitoring of previous policies has not been a priority. New policies have been crafted without referring to lessons learned from previous evaluations. Getting access to routine data, even for researchers, is not easy
- Staff in the mission sector face disadvantages in terms of their pension arrangements, compared to government workers, and barriers to promotions within the sector
- The private sector is sustained by dual practice by public health staff; however, our findings for the private sector were limited due to their unwillingness to participate in the research

Table 1: Total monthly income from all sources by profession and sector (USD)

Cadre	Government	Municipality	Mission
EHPs	293	1,206	334
Midwives	324	1,501	248
Nurses	324	976	279

Source: ReBUILD health worker survey, 2012

Figure 1: Factors reported by staff which motivate them to stay in their posts



Source: ReBUILD health worker survey, 2012

Effects of incentives

- The rural areas were not well staffed with some health facilities not having a single midwife.
- Remuneration stands out as the single most important factor influencing health worker behaviour (see Figure 1) - health workers would prefer salary increases to piecemeal incentives
- Life histories find an erosion of nursing ethics over time— health workers are now more concerned with monetary returns to their labour inputs
- Provision of accommodation emerges as a major factor which encourages staff to work in rural areas (mentioned by half of the staff surveyed)
- Health worker attrition rates have reduced following implementation of the harmonised retention scheme in the public sector, suggesting that incentives can work to retain skilled HRH in the short term
- The poor harmonisation of retention schemes (HRS, HTF, RBF) in the sector affects motivation and service delivery
- The inequities in remuneration and incentives within the service (municipal, RDCs, government, mission, private) creates an unequal internal labour market. Urban municipalities are able to pay health staff on more lucrative local government scales or top up health worker salaries from numerous revenue sources which are not available to other sectors (see table 1). This concentrates critical skills in municipalities, at the lowest end of the referral chain (e.g. midwives at primary care level) and with lower workloads.
- Allowances like the rural area allowance are not substantial enough to offset the disadvantages of rural living and working.
- Training opportunities have become a demotivating factor because of the perception that selection is not based on merit.

Recommendations

1. Successful implementation of reforms require much more time for planning, informing and consulting health workers, and mobilising political and financial support
2. The distortions created by the differences in remuneration must be addressed to ensure proper distribution and utilisation of skills, so these are available where they are most needed
3. Salaries in government, mission and rural council sectors must compare reasonably with municipality salaries, in order to stem internal migration of health workers
4. The status of mission, rural council and municipality health workers should be aligned with public sector conditions of service to resolve the existing inconsistencies regarding pensions and grading systems.
5. Retention strategies should target all staff categories, to curb migration of staff at all levels
6. The rural area allowance should be tailored to reflect the different degrees of remoteness—at present, the policy applies equally to areas close to conurbations as to genuinely remote areas, and is very limited in scale
7. The issue of high workloads in the government sector should be addressed by ensuring that the establishment is revised and that the new posts created are filled
8. Policies (such as the HRH Strategy of 2010) should be monitored and evaluated and the data and findings from such processes should be made available to a wide audience
9. The HSB needs to be accorded the autonomy that is enshrined in the Health Service Act and the resources for it to be able to resolve long-standing problems of high turnover of health staff
10. The RBM performance appraisal system should be implemented uniformly in all provinces so that it really motivates high performers
11. Incentive schemes should be harmonised to ensure that they promote fairness and rational service delivery
12. Selection for training should be carefully monitored to ensure that service needs and individual merit are prioritised

For more information see:

Chirwa et al., 2013, Understanding health worker incentives in post-crisis settings: Zimbabwe document review

<http://www.rebuildconsortium.com/media/1010/understanding-health-worker-incentives-in-post-crisis-settings-a-document-review-of-zimbabwe.pdf>

Find out more on ReBUILD's work in Zimbabwe and beyond

Visit the ReBUILD website: www.rebuildconsortium.com.

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