

Understanding health worker incentives in post-crisis settings: policies to attract and retain public health workers in Zimbabwe: key informant interviews

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The ReBUILD Research Programme Consortium is an international research partnership funded by the UK Department for International Development. ReBUILD is working for improved access of the poor to effective health care and reduced health costs burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality, policy-relevant research evidence on health systems financing and human resources for health, and working to promote use of this evidence in policy and practice.

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List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
DMO	District Medical Officer
DNO	District Nursing Officer
EHPC	Environmental Health Practitioner Council
EHT	Environmental Health Technician
EHO	Environmental Health Officer
EU	European Union
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSB	Health Service Board
HTF	Health Transition Fund
IDIs	In-Depth Interviews
KIIs	Key Informant Interviews
MOHCW	Ministry of Health and Child Welfare
MRCZ	Medical Research council of Zimbabwe
PCN	Primary Care Nurse
PMD	Provincial Medical Director
RCZ	Research Council of Zimbabwe
RGN	Registered General Nurse
RBF	Results Based Financing
SCN	State Certified Nurse
SSB	Salary Services Bureau
STERP	Short Term Emergency Recovery Program
TB	Tuberculosis
VHSSP	Vital Health Services Support Programme (EU)
WHO	World Health Organization
ZACH	Zimbabwe Association of Church-related Hospitals

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Executive Summary

Introduction

Incentive environments for key human resources for health (HRH) cadres in Zimbabwe in the wake of the severe economic, social and political crisis is an area of immense importance for rebuilding the health system. This study's main goal is to understand the post-crisis dynamics for HRH and ultimately how to reach and maintain incentives to support access to affordable, appropriate and equitable health services.

Objectives and research methods

The main objective of this sub-component of the study was to understand key informants' perceptions of health worker incentive policies, their evolution in the post-crisis period, their implementation and effects. This was a cross-sectional, retrospective study, focusing on the difference between key categories of health staff employed in different sectors of Zimbabwe's health system. A semi-structured key informant interview (KII) guide was used in face to face interviews with selected officials from the municipality, council, private for profit and not for profit, faith-based, and public sector health service providers. Districts (3) and key informants (28) were purposively selected. Data from KIIs were colour coded, sorted and analysed using a pre-prepared grid of themes. Ethical approval was sought and granted by all the relevant authorities.

The study focused on the evolution of policies on retention and incentives across four key provider sectors and sub-sectors: the public sector, municipal and or rural councils, mission and private for profit. These are the backbone of Zimbabwe's health system. We were able to collect and analyse data from three groups (the public sector, municipal and/or rural council, and mission) across three districts, but were unable to access data from the private for profit providers, largely due to their unwillingness to participate.

Findings

Retention and incentive policies in Zimbabwe's health system have been very contentious since independence and began to attract attention at the onset of the socioeconomic crisis in 1997. The early attempts to improve incentives for the health sector were part of the wider public sector reform programme through the introduction of a performance management system. This did not improve the retention of health workers in the public sector. The flight of health workers became serious and in response an enquiry into the health sector was instituted. Its key recommendation was that the health sector be managed independently from the wider civil service to address the unique aspects related to health worker retention. The Health Service Board (HSB) emerged to manage and administer all issues related to HRH.

As part of its mandate the HSB made attempts to improve the incentive environment and retention of health workers. Some key initiatives included periodic salary increments, critical area allowances, improvement of existing allowances and introduction of new allowances, and vehicle purchase schemes. These initiatives were affected by reduced funding for the health sector as well as arguments with other governmental departments over the preferential treatment of the health workforce implied by these incentives. This led to policy fluxes that increased salaries and allowances and then reversed these increases after short periods of time, which fuelled disaffection in the health workforce. The introduction of the harmonised retention scheme with funding from development partners after the crisis in 2009 succeeded in stabilising the health workforce situation in the public sector, although disaffection later began to creep in again as a result of the phased reduction of the retention allowances. The successor programmes to the harmonised retention allowance, the results based financing and health transition fund, have divided health workers as the rationale for who is benefiting is not clearly understood.

The municipality providers responded to the crisis situation in a more robust manner resulting in them becoming the most sought-after employer of health workers. This is because the municipalities collect revenues from rate payers and are able to channel that revenue to key sectors like health. There is also the aspect of accountability to the rate payers who have oversight on the activities of the municipality. Municipality providers adopted policies that were effective in attracting and retaining health workers. During the crisis, health workers in the municipality were paid in cash in response to a shortage of cash in the economy. They were paid every two weeks to ensure that salaries were not eroded by inflation. A host of measures that improved the general remuneration of health workers were introduced, including the regrading of health workers using the local government grading scheme. The new grading system led to a net increase in salaries. New allowances like access to land for residential purposes, targeted allowances for cadres who had shown loyalty, subsidised water and sanitation rates, and medical insurance made the municipality attractive to health workers. These were maintained and strengthened after the crisis. Post-crisis evaluations have concluded that the municipal providers are enticing workers away from the public sector because of the attractive incentive environment.

The study also established that the status of the mission sector work force is problematic: mission staff sign two contracts (with government and the mission sector) and the relationship to the government is not clear to them. They see themselves as government employees but formally they remain mission employees and their pension scheme is separately administered. This creates unfavourable terms and conditions. The withdrawal of

direct funding by churches to mission hospitals has meant a decline in standards in mission hospitals. Similarly, the rural district council health workers also face challenges as their remuneration is pegged according to public sector salary grades which make their remuneration less in comparison to rural district council salary grades. The incomplete regularisation of the status of mission sector and other sectors considered public sector is an impediment to the implementation of HRH policies equitably to achieve a harmonised health service.

The key actors in change processes are the government and development partners. Historically, these players have most influence, with development partners' influence becoming more apparent during and post-crisis. Other government departments are also important, especially where health worker supply depends on intersectoral cooperation to harness resources to implement policies, but adequate funding on a sustainable basis is the key driver of change.

Conclusion

The socioeconomic crisis in Zimbabwe affected all dimensions of HRH planning and management in all provider organisations. Despite early warnings from the commission of enquiry in 1999, delays in acting on recommendations gave impetus to rapid deterioration of health worker availability and distribution for the public, mission and rural district council providers. Retention policies were often implemented for short periods of time and reversed, fuelling health worker flight from the public sector.

The quest of the HSB to usher in a new ethos where the health service would be treated differently from the wider civil service was thwarted, because of arguments among governmental ministries. However, the municipalities came up with policies that were quite effective in making them attractive to HRH and this tended to maintain staffing levels during the crisis and in the post crisis period. The mission sector faced challenges because their status was unclear with regards to their conditions of service. HRH in mission sector salaries are paid by the government, yet their pensions are managed by a private insurer appointed by the Zimbabwe Association of Church-Related Hospitals (ZACH).

Our analysis suggests that good remuneration and allowances impact positively on the retention of health workers. The introduction of the harmonised retention allowance in the post-crisis period had a positive impact on health worker motivation. The retention allowance saw absenteeism decrease and other economic activities at health facilities conducted by health workers reduced.

Recommendations

- Fragmented human resources planning and management is causing disparities in remuneration levels. The HSB should exercise its mandate to manage HRH in all sectors to harmonise remuneration and reduce internal health worker migration.
- The crisis provided opportunities for the formulation of dynamic policies to respond to the challenges being faced by health workers, including the introduction of targeted incentives. Integration and regularisation of such incentives into the remuneration package of health workers in the long term should be pursued. The retention and incorporation of allowances into salaries will enhance pensions, which most health workers perceive to be very important, and thus retain the most experienced staff.
- Health workers should be adequately informed about incentive programmes, especially with regards to the rationale of selecting employees, to avoid some cadres of staff hearing about such policies through the grapevine.
- Implementation of HRH policies is a complex process that requires the cooperation of several government departments which often have different interests. There is need to develop a mechanism that promotes sustained engagement among the key government departments that have a role in health administration to ensure coherent remuneration policies across key public service sectors.
- The use of evidence in developing HRH policies needs to be strengthened, particularly with respect to the timeliness of translating evidence into practice as issues change over time.
- There is the need for evaluation of HRH policies by health workers themselves to provide experiential insights on the effects of policies.
- Incentive packages to minimise rural to urban migration are general, as most of them apply to all health workers, except the rural area allowance. It is important to come up with uniquely rural allowances that focus on push factors. Educational allowances to support the education of offspring and low interest loans to help improve livelihoods are important incentives that need special attention.
- There is the need to revisit the recommendation of the review commission with respect to the role of the HSB, so that its current limitations are improved.

Introduction

Background to the research

ReBUILD is a research programme concerned with health system development in post-conflict or post-crisis countries and aims to develop lessons for governments on how to make or recreate and sustain fair health systems. Understanding health worker incentives in post-conflict or post-crisis states is a component of the wider ReBUILD study undertaken specifically to explore the current incentive environments for key human resources for health (HRH) cadres in Zimbabwe. Zimbabwe experienced a severe economic, social and political crisis that lasted close to a decade and had a negative effect on the entire health system that can still be felt today.

The four sectors and sub-sectors - public, municipal/rural district council, mission and private - constitute the main health providers in Zimbabwe. The MoHCW regulates all of these provider organisations and provides grants for the mission and municipal/rural council providers. The private providers independently fund their institutions, but sell their services for profit.

The four sectors have specific HRH policies for enhancing health worker performance, retention, patient care and health outcomes. However, they differ in terms of HRH planning and management, conditions of service, workloads and skills mix. This variation fuels the internal movement of health workers to sectors offering attractive conditions of service (Health for all Action Plan, 1986; National Health Strategy 1997–2007:51; Sikhosana, 2005, McPake et al, 2013, Witter et al, 2011; MacKinon et al., 2012, Chirwa et al, 2015).

Zimbabwe, once renowned in the sub-Saharan region for providing high quality, accessible and affordable health care services, experienced a severe socioeconomic crisis between 2005 and 2008. The health sector experienced sharp decreases in funding, deterioration of health infrastructure, loss of experienced health professionals, drug shortages, increased burden of disease and high demand for services, which all inevitably led to a drastic decline in the quality of health services available for the population during the crisis (MoHCW/HSB 2010, GoZ, STERP, 2009, NHIFA, 2012). The crisis created a severe workforce deficit in the health system (HSB & MOHCW 2010). The availability of human resources for health (HRH) in the right numbers, at the right time and place, with the appropriate skills mix and willingness to stay in their jobs is a critical aspect of health service delivery.

The crisis affected HRH and led to serious attrition in the entire health sector. Considerable emigration of health workers from the country occurred, and government-run institutions also lost many health professionals to private organisations. HRH were migrating from the public health sector because of low morale aggravated by low salaries,

limited support and supervision, unsatisfactory working conditions and poor budget support (GoZ, 2010). As a result, the health care delivery system faces challenges in recovering from this crisis (HSB 2010b). There has been no profound improvement in HRH attraction and retention despite significant progress in resolving some of the causal factors of the high attrition of HRH in the immediate post-crisis period.

Objectives of the sub-study

Overall, the main goal for the entire research project is to understand the post-crisis dynamics for HRH and how to reach and maintain incentive environments for health workers, to support access to affordable, appropriate and equitable health services.

This sub-study aims to understand key informant perceptions on health worker incentive policies, their evolution in the post crisis period, their implementation and effects.

Research Questions

- i. How has HRH policy evolved in the post-crisis period?
- ii. What have been the drivers of the policy changes?
- iii. What have been the implementation challenges for the HRH policies?
- iv. What have been the effects, intended and unintended of the policy changes?
- v. Given the context and the available evidence, what strategies might be adopted in future to improve health worker attraction, retention, performance and distribution, especially in relation to the most disadvantaged sections of the community?

Research methods

Approach used

This report presents and analyses KII data of the health worker study. The overall study was cross sectional and retrospective, focusing on the difference between key categories of health staff employed in different sectors of Zimbabwe's health system. KIIs are a qualitative research method, which is complemented by indepth interviews (IDIs), document review, secondary data analysis and a health worker survey. For more details on the overall methodology, see the Research Protocol Summary [Witter et al., 2012] on the ReBUILD website.

Research tool

A KII guide was used to conduct semi-structured interviews with selected officials. The key informant guide was developed in collaboration with other members of the ReBUILD consortium. In Zimbabwe the key informant guide was then adapted to the context and pretested in a non-participating district. It was revised after the pre-test to come up with the final KII guide.

Study sites

The study was conducted in two administrative provinces. The two provinces were selected because they had a diverse range of health care employers and so distribution, attraction, retention, and performance of HRH could be comparatively analysed. Three districts were selected based on the availability of municipal and or council, private for profit and not for profit, church or mission and public sector providers of health care. One wholly urban district with a diverse spectrum of health institutions was selected. The second district had both urban and rural sectors and a third district was a rural district. The selection of the study sites was informed by the broad objective of comparing inter-provincial, intra-provincial and inter-sectoral variations in incentive environments and their effect on HRH retention.

The institutional level key informants were managers at health facilities. Participants in this category included hospital superintendents, directors of health services (municipalities), directors of operations (public sector central hospitals), medical officers, principal matrons/ nursing officers and health service administrators as shown in Table 2 below. Key informants had served for periods ranging from 15-45 years in the health sector. Sixteen KIs were conducted at the district level. Altogether 28 KIs were conducted.

Sample size and sampling methodology

The participants in KIs were selected purposively from key stakeholder institutions (government, donor, municipal, private and mission) involved in HRH policy formulation and implementation. The national level interviews included MoHCW head office staff, Public Service Commission (PSC), HSB, registrars from professional associations, donors and development partners. A total of twelve interviews were conducted at the national level as shown in Table 1 below.

Table 1: Description of national key informants

Sector	Organisation	Gender	Total
Public health sector	Health Service	Male	1
	Public Service	Male	1
	MoHCW	Female	1
	MoHCW	Male	1
	MoHCW	Male	1
	MoHCW	Male	1
	MoHCW	Female	1
	MoHCW	Male	1
	MoHCW	Male	1
Health Professions Associations	Environmental Health Nurses Council	Male	1
		Female	1
Development partners	Health Advisor	Male	1
Faith Based health sector	Manager	Female	1
Total			12

Table 2: Distribution of district-level KII

District 1			
Private Hospital	Hospital Administrator	Female	1
	Doctor	Female	1
Municipality	Administrative Officer	Male	1
Municipality	Nurse in charge	Male	1
Public sector	SNO III	Female	1
Public sector	HR Assistant	Female	1
Total			6

District 2			
Mission	HR/Administration Officer	Female	1
Municipality	Matron	Female	1
Municipality	Municipal Health Administrator	Male	1
Public Sector	HR Officer	Male	1
Private Sector	Executive Officer Health	Male	1
Total			5

District 3			
Mission	Acting Matron	Female	1
Public Sector	Nurse in Charge	Female	1
Public Sector	Nurse in Charge	Female	1
Public Sector	DEH manager	Male	1
Public sector	District Nursing Officer	Male	1
Total			5
Grand Total			16

Fieldwork

The key informant guide was pre-tested in January 2012. The KII data collection started in February 2013 and continued through 2014. The KIIs at national level were conducted as and when the people selected had given dates and time slots for the interviews. Fieldwork in the study sites started in district 1 on 5th February 2013 until 22nd February then in district 2 and 3 data collection was done between 12 May and 26 May 2013.

Data analysis

Responses from KIIs were analysed starting from a pre-prepared grid of themes, to which additional themes arising from the data were added. Our conceptual framework explored the interconnectedness and dynamic relationships among various factors that have a potential to impact on attraction, retention and performance of HRH. Our conceptual framework contends that contextual factors, health worker factors and policy levers interact in particular ways to produce both intended and unintended outcomes that impact on health systems. A further assumption we make is that past experiences influence present expectations and behaviours (health worker factors) while external factors (context factors) also influence developments in relation to expectations and behaviour as depicted in Figure 1. Hence data was collected that would allow retrospective analysis of this dynamic interconnectedness of these factors both in the pre-crisis, crisis and post crisis phases. The analysis below attempts to describe the dynamic relationship between context factors, health worker factors and policy levers.

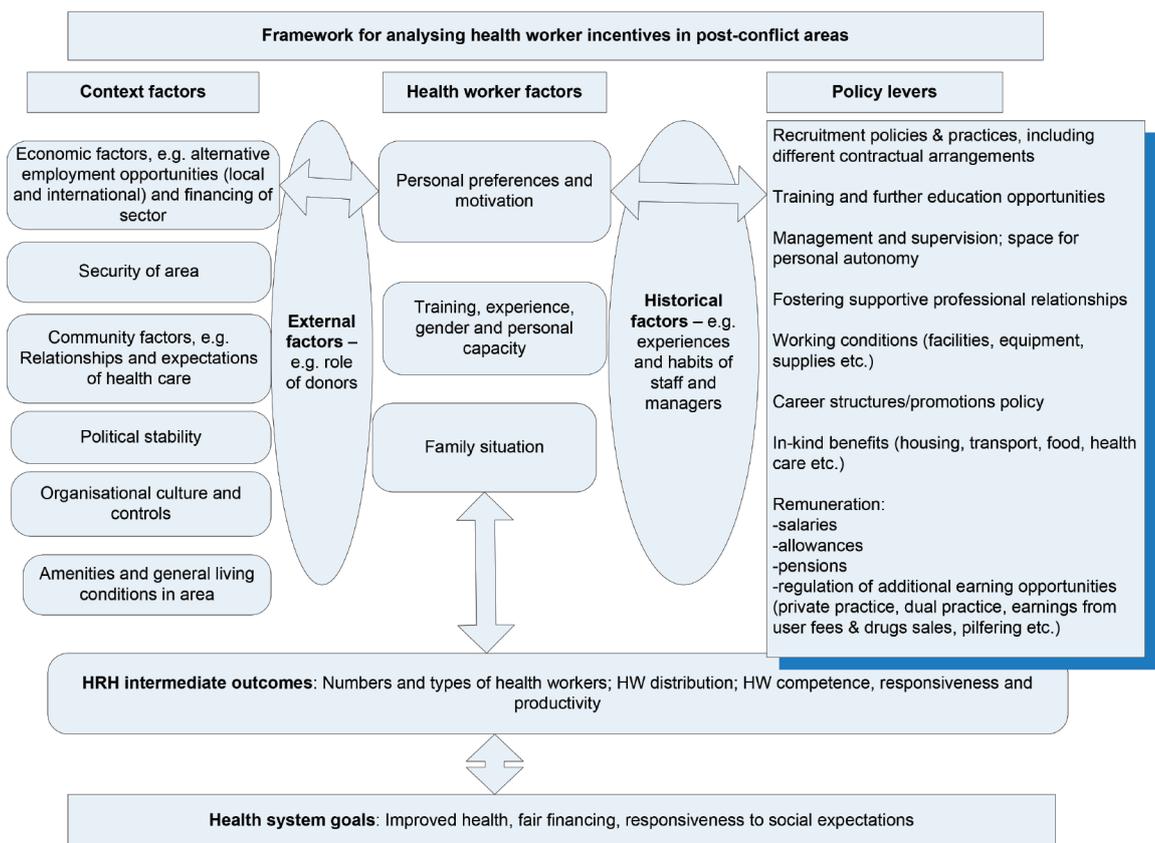


Figure 1. Conceptual Framework

Research ethics

The protocol for the study was reviewed by the institutional review board which granted approval on 13th June 2012. Ethical permission was obtained from the Medical Research Council of Zimbabwe (MRCZ) on 2 January 2013. Further review was done by the Research Council of Zimbabwe (RCZ) as is required with all research involving collaboration with international partners. The study was also approved by the Liverpool School of Tropical Medicine.

Participants were informed about the objectives of the study, why they had been chosen, and the risks and benefits of participating in the study before the interviews. The participants were afforded the opportunity to ask questions or make comments and then make a decision to participate. An information leaflet was provided to all participants through the head of the institutions they were affiliated to. A consent form which participants were asked to read before the interview also provided further information. The participant then made a decision to participate voluntarily and was asked to sign two consent forms. The participants were assured that the whole process would uphold the highest standards of confidentiality and that their participation would be anonymised. One copy of the signed consent form was given to the participant for their records and the researcher retained another copy to be kept with all

other research records securely in a locked room only accessible to the lead researcher.

Research limitations

There were limitations related to the general environment as well as limitations intrinsic to the research process. Environmental limitations included the challenge of carrying out KIIs in a situation where participants were uncomfortable discussing sensitive issues. A typical area that participants were unwilling to discuss was that related to security. Some of the key informants were suspicious of the interviewer and failed to respond to questions citing the sensitivities related to causal explanations of the economic crisis. Some key informants from the private sector and the mission sector were not willing to participate. The private health sector was difficult to access for research purposes. Previous assessments and studies have acknowledged this fact (See Gupta et al 2009, NIHFA 2012). The effects of the crisis were still affecting private providers and any attempt to research on HRH issues was not acceptable as this would put the institution into the spotlight. The time taken to arrange interviews was another limitation that delayed data collection. Some of the appointments were cancelled on the day that the interviews were supposed to take place. This has to do with the nature of face to face interviews with key informants who are normally busy during working hours. A final limitation is that the

study focussed on health worker and management perspectives only.

Findings

Evolution of health policy

After independence, the health sector faced challenges, some of which were a result of the colonial dual health policies. However, after 1997 more acute hurdles emerged as a result of the socio-economic crisis. There were challenges in attracting and retaining health workers as funding for health expenditure decreased. The HRH in post were also migrating, both within Zimbabwe and to other countries, leaving vacancies that were difficult to fill. The training of health workers was also affected, so the training capacity for HRH to replace those that were leaving could not be expanded. All of these challenges occurred at the same time as the burgeoning HIV/AIDS epidemic, putting further strain on the health system.

The evolution of health policy in Zimbabwe can be categorised into three phases, the pre- crisis, crisis and the post crisis as shown in Table 3. The pre- crisis period (1992-97) was characterised by policies that focused on improving remuneration through the systematic evaluation of job descriptions. In 1996, a performance appraisal system was introduced for public rural district councils and mission sectors. Around 1997 the government took over the administration of all health facilities providing services to the wider public, which included all Rural District Council facilities, mission and municipalities. There are suggestions that this arrangement has not been finalised.

The crisis period saw the promulgation of the Health Service Act 2004, which paved the way for the formation of the HSB, in an effort to better respond to HRH needs. In 2005, a new performance management system Results Based Management (RBM) appraisal system was adopted. In 2007, several policy initiatives were adopted which included the introduction of hospital boards tasked with the recruitment of selected health worker grades, duty free importation of vehicles for selected health worker grades and the introduction of a targeted incentive scheme in the 24 poorest districts.

“The Health Service Board is there to set policies on Human Resources as the employer, the onus of implementation is upon the Accounting Officer. ... [The Ministry of Health through the Director HRH [MoHCC] provides technical expertise] in terms of implementation. We have got four major thematic areas that we run with. We are looking at human resources for health information system and research, we look at health worker training and development, and the third area would be recruitment, selection deployment, management and retention of the health workforce. The last area would

be HRH planning and financing that would cover the majority of the HRH issues that we would want to dwell on.” (KII 013 National Health Manager)

In the post-crisis period, initiatives to address attrition included the harmonised HRH retention allowance in 2009, Results Based Financing (RBF) in 2011, and the Health Transition Fund (HTF) in 2012.

“The HTF is supporting all the health workers in grades C5 and above. Probably the challenge that we have is that the paying agent is the same so people believe this is only coming from the harmonised retention because HTF is complimenting whatever government is doing. RBM is another framework which is targeting health facilities to improve on performance areas like MNH and it also deals with incentives.” (KII 013 National Health Manager)

Table 3: Evolution of HRH policies in Zimbabwe, 1992-2012

Period	Year	Policy intervention	Scope
PRE-CRISIS	1992	Job evaluation introduced	Public Sector National
	1996	Performance appraisal system	Public Sector National
	1997	Government takes over all health facilities serving wider population	National (Mission, Municipality, Rural district council health facilities)
CRISIS	2004	Health Service Act Health Service Board created	National
	2005	Results Based Management	National
	2007	Decentralization of recruitment to hospital boards Duty free vehicle importation (Selected health worker grades) Vital Health Services Support Programme	National 24 Poorest Districts
POST- CRISIS	2009	National health strategy Harmonized Human Resources for Health Retention allowance	National
	2010	Freezing of posts	National
	2012	Health Transition Fund	National (Selected districts-incremental)

Public sector policy

Immediately after independence, health sector development was informed by the Health for All Action Plan (1986). This plan emphasised equitable access and so the rapid expansion of health service delivery was pursued with relative success. Between 1997 and 2008, political and social conflicts, mainly arising from the land reform programme, culminated in the imposition of “restrictive measures” on the government. The crisis period was characterised by a serious economic and social crisis which began to subside with the formation of a government of national unity in 2009. This helped put Zimbabwe back on the road to recovery. Health sector

policies adopted during the crisis include the creation of the HSB in 2005. The HSB also was mandated to spearhead the implementation of the government results based management system (RBM). The RBM replaced the previous performance management system and implementation began in 2005. Since its formation the HSB decentralised staff appointments and improved other health worker benefits. In the immediate post crisis period the MoHCW, HSB and development partners introduced a harmonised health worker retention policy to help revitalise the health sector by ensuring that health workers return to work.

Creation of the Health Service Board

The creation of the HSB in 2005 was a key response to the health sector crisis. The HSB administers and manages health workers and their affairs. The creation of the HSB was seen as progressive and indicative of renewed efforts to address the poor working conditions in the health sector. The HSB is supposed to manage all affairs of health workers in the public sector, which encompasses mission, municipal and RDC providers. In practice, the HSB has little influence on municipal and private sector health workers although the government position is that the municipality is part of the public sector.

According to key informants, many useful initiatives to address problems affecting health workers in the past targeted public health sector workers. Issues that needed urgent redress, such as low salaries and poor benefits, were more acute in the public sector than in other sectors. Key informants recounted that the evolution in health policy should be understood in the context of the 1999 presidential review commission into the health sector. The commission recommended a raft of changes in the health sector. Not all recommendations of the commission were adopted, but it was the commission that unflinchingly stated that the HRH crisis in Zimbabwe was due to a dysfunctional regulatory framework for HRH which grouped them with all other public service workers. This framework, which did not acknowledge the uniqueness of the health sector, was no longer tenable and efficient and had to change.

“The reason for challenges in the health sector were spelt out clearly in the review of the health sector findings. The commissioners who were prominent health sector experts, noted that the health sector needed to be radically changed in terms of HRH management. As of now the health sector is unwieldy and the coordination of providers is weak. Providers are awarding different benefits and the relationship between providers is not clear and the burden of service provision is skewed and all these are not considered in setting up of pay grades. This is why the review recommended a health service commission which would ensure that all health providers, public, mission, municipality,

rural district council, private for profit and not for profit are administered by this commission. Umm this is not what happened and recommendations of the review commission were late in being implemented and were not implemented fully in some cases. The HSB for example is not what the review had recommended but it was a sort of compromise to have the board rather than the commission. The HSB was supposed to have authority on HRH in the health service, but it does not and this is a big problem.” KII 017 National Health Manager

The general expectation among health workers was that the creation of the HSB was going to transform the health services sector and make the implementation of HRH policies efficient. The HSB was tasked with implementing a lot of HR initiatives and it managed to implement the recommendations of the job evaluation.

“... having a board that looks after the interests of health workers as is supposed to be done by the HSB was a good thing. Immediately after the HSB came into existence there were changes that happened to the conditions of service but the problem was that there were no resources... money was tight but there were good intentions by the HSB for example some of the recommendations of the job evaluation were brought on board like giving health workers good salaries, introduction of allowances like post basic. All health workers were happy and expected a lot of good things but like I said the HSB came when a lot of problems had beset the country.” KII 017 National Health Manager

The HSB tried to work together with the PSC to implement policies that would improve the terms and conditions of the health workforce. The problem with this was that some managers felt there was duplication, which increased their workload.

“The nature of all government bureaucracies is that they need uniformity, orderliness and clearly defined mechanisms of managing the many units that form government. We have the army, the police, immigration and revenue departments who seem like they are autonomous but in the final analysis the public service commission is the ultimate authority on all aspects of government sector human resources because without that the system we will become fragmented and disorderly ... the result being a very weak government.” (KII 018 Public sector manager).

“You will find that the Public Service’s interest is coming from the public interest. The Health Service Board is the employer of health workers and when they [Public Service Commission] monitor through their structures it is an interest in terms of first-hand information on how health services are provided, so

to me the only challenge is like I said we are looking at an overworked team [health workers] where once the hierarchy comes you drop everything and attend to them, that will be where the concern is but if your things are in place you will be happy to show case what you are doing and also raise your concerns with the various players because you never know who is going to listen to you, but to me the only concern ... we have got so much to do and limited time and then there is this delegation [PSC] before they leave there is another delegation [HSB] and then they have got technical people who come also wanting the same demand on them, but to me everyone has got their place in the whole system.” (KII 013 National Health Manager)

Health workers feel that the government has not been keen to improve the terms and conditions of health workers over time, despite the evidence that came from the job evaluation in the 1990s.

“Everyone in the health sector knows that the government made a commitment to bridge the gap between employees that are in its institutions after the job evaluation ... and in the health sector the recommendations were not implemented. the argument being that this would create disharmony in the civil service” (KII 017 National Health Manager)

The reasons for not following through with the recommendations of the job evaluation were not clear but key informants suggested that budgetary constraints may have made it difficult to implement the recommendations. However, the failure to deal with these issues are responsible for the weakening of the health sector epitomised by work stoppages. Strike action was an indication that the health workforce was not happy with their terms and conditions and that the MoHCW was not giving due attention to the deterioration of health service delivery.

“Between 1992 and 1996 the health workforce went on job stoppages numerous times aah I think there were more than 5 strike actions during that period ... the reason why these strikes were happening are clear to everyone it is the failure to address known problems affecting the health workers. All key health workers went on strike during this period but doctors were the most disaffected as they went on strike more than other cadres, then the nurses and laboratory technicians and radiographers did go on strike at some point.” (KII 017 National Health Manager)

The creation of the HSB in 2005 came at a time when the economic status of the country had deteriorated. Key informants mention that a number of strategic positions in the HSB were not filled for some time as a result of inadequate resources. Ideally, some of these functions had to be done by the MoHCW. The HSB and the

MoHCW are therefore inseparable as entities, even after the crisis. The HSB continues to rely on the MoHCW as described in the following excerpt:

“The responsibilities of the Ministry of Health in terms of human resources for health..... in summary is just oversight over the implementation of the Human Resources for Health policies that are set by the Health Services Board.” (KII 013 National Health Manager)

One key informant observed that:

“Since formation in 2005 the HSB did nothing but look for the right staff and it was also affected by exodus of the few people who had been appointed. In 2007 the HSB made some progress in convincing the public service to review salaries of health workers but only for three months. The current constitutional review process is also suggesting the creation of a strong Public Service Commission which means that the HSB will have to live with the fact that it cannot make change for the health workers without the approval of the commission.” (KII 017 National Health Manager)

Since its formation, the HSB came up with a raft of incentives to make working in the public sector attractive. It also made strategies to curtail the movement of HRH from rural to urban areas.

“Some of these strategies implemented beginning around 2007 at the height of the crisis were a rural allowance (equivalent to 10% of basic salary) for remote areas, support for the relocation of HRH’s spouses and accommodation.” (KII 017 National Health Manager)

These were direct individual benefits accruing to the health worker. There were other initiatives that also sought to improve general working conditions and to encourage HRH to stay in rural areas. These included upgrading rural health facilities, and offering educational allowances and low-interest student loans to workers interested in furthering their professional development. To manage the movement of workers from the public to the private sector, as well as overseas, regular reviews of salaries and allowances were planned. However key informants noted that these remained as plans and were never implemented.

“... there has never been any change to the health infrastructure in the district for the past ten years. Working conditions are affected by this and we have to work long hours and patients have to wait. This is despite the fact that we now have several programmes like PMTCT, nutrition, paediatric HIV and opportunistic infections that require their own work stations introduced in the past few

years. Working stations are a challenge for health workers and we have to make clients wait long as we clear the work stations to begin work on other programmes.-There is no support for health workers who are furthering their studies- some are told to go on study leave – but they pay fees and are supposed to be reimbursed but this takes time and ends up aggrieving the health worker who feel that they are being unfairly treated- things like this also force health workers to leave – remember these are now holders of higher skills and they get frustrated and go to the private sector or to the diaspora.” (KII 03 Health administrator district 2)

Results Based Management

The RBM system that was introduced in 2005 to reward and motivate high performers was to be strengthened. The RBM was meant to be a retention mechanism, which would reward HRH based on the attainment of pre-set performance targets. The RBM was being implemented to improve on inadequacies of the 1996 performance appraisal system.

“In the RBM performance management system, individual HRH set objectives which they have to achieve at the end of a defined period, they also indicate the resources that will be needed, as well as training and support that is needed to achieve the objectives. These are agreed with the immediate supervisor. This process creates what are termed Key Result Areas (KRAS) which will be the basis of assessing performance at the end of the evaluation period. The immediate supervisor may recommend salary advancement, if the appraisee has achieved the set objectives, or further training or increased resources if the objectives are not achieved.” (KII 017 National Health Manager)

Key informants noted that the RBM has been implemented slowly across the public health sector because some districts completed the relevant forms whereas others did not.

“In the districts the RBM forms are being completed and there is a deadline that has been set.. but when we meet as a province we hear others saying the forms are not there we do not know why this is the case. So what it means is that some districts will benefit from the appraisal process but others will not and this is a problem for district managers. You know health workers meet in town during pay days and they discuss this and we have to explain some of these issues but who will believe you?” (KII 021 Health Manager District 3).

Decentralised recruitment

The recruitment of health workers was decentralised to the provincial and district hospital boards in 2007. This decision was taken because there was a high turnover

of staff across all departments in hospitals and clinics, particularly in rural areas. According to key informants, this worked well for support staff posts like general hands, nurse aides and cooks during the crisis and still works well in the post-crisis period. However, participants observed that for clinical staff there has been no improvement recruitment after decentralisation.

“Recruitment of health workers was difficult in 2007 and much time was spent doing appointments. Many health workers were leaving their jobs and we were trying to recruit to replace those that were leaving. You would appoint someone but they would never come or they would come and say they no longer wanted the post. there simply were no health workers and even the non-clinical staff were not available. ...we only began to get staff to recruit as general hands when the qualifications were lowered but then the general hands that were recruited quickly deserted their posts.” (KII 020 Provincial health service manager district 2)

In 2010, the freezing of posts further compromised the decentralisation initiative for the recruitment and promotion of clinical staff. According to the HSR 2006, the recruitment of clinical staff could be done at the district level with the central level only endorsing that the process had been done according to the rules. According to a key informant, the freezing of posts made recruitment even more bureaucratized and complicated:

“The freezing of posts has doubled if not trebled the time it takes to recruit health staff. The process of seeking Ministry of Finance concurrence, then advertising, holding interviews and then getting acknowledgement from the Ministry of Finance took almost six to nine months. By the time this process was complete the prospective employee would have either got a job elsewhere or become uninterested. This was particularly common with critical cadres like specialist doctors and midwives. So at the end of the day the Public health sector spent a lot of money through this process but with no one being recruited. In isolated cases where the recruitment succeeded through the MoF concurrence model during the freeze the post being filled would be tied to the successful candidate and in case that individual decided to resign, which was the case in most circumstances the post would become frozen. To recruit the whole process had to be redone and that would take another six to nine months.” (KII 020 Provincial health service manager district 2)

“The freezing of recruitment for government workers including health workers made it difficult to fill vacancies in the public health sector. The same regulation affected recruitment in the mission sector, the municipal and rural council providers because these providers receive grants from government.

Since the objective of the freeze was to cut government recurrent expenditure, the health grant to these provider organisations had to be monitored. The impact of the freezing of posts was not severe for municipal provider organisations because vacancies were not as high because resignations were not as frequent as in the public sector. It was also easy for managers in the municipality to move health workers to areas experiencing health worker shortages within their various precincts. (KII 009 National Health Manager Mission Sector).

Challenges in the health sector became extremely entrenched according to key informants. Responding to the question about the situation of health workers in the public sector before 2009, when efforts to resuscitate the health sector commenced, a key informant in district one said:

"The challenges were just phenomenal. The operations of the health ministry were affected to the extent that virtually all dimensions of service delivery, the curative, PHC, HRH production, recruitment and retention became dysfunctional. Human resources planning and management ceased to be an issue. Each day was planned for as and when it dawned. All systems of HRH were no longer functional. Leave applications were no longer done by HRH; health workers just did not come to work at the height of the crisis. There was no commitment to the profession. For the HRH departments the main activity became setting up of disciplinary hearings." (KII 020 Provincial health service manager district 2)

The harmonised retention scheme

The harmonised retention scheme was initiated through a multi-donor fund to help revitalise the health system immediately after the crisis. The retention scheme catered for public, mission, RDC and municipality sectors. On inception in 2009, the retention scheme sought to lure back and retain health workers who had left the health service. To achieve this, salary top ups of 100% of basic salary were introduced for all health workers. However, this was changed after 3 months to include health workers at grade C5 and above. The harmonised retention scheme was an agreement between the government and donors. The agreed conditions were that health worker salaries would be increased by the government at a rate corresponding to the reduction in the retention allowance being funded by donors. This meant that if the retention allowances reduced by 25%, the salaries of health workers would appreciate by a similar rate. It was anticipated that by 2013 the retention allowance would cease altogether and be replaced by a competitive salary that was attractive to health workers. Key informants from the other non-government providers were not clear on the status of the harmonised retention allowances. There were not aware of the change in the initial format, which posited the retention scheme as a

way to provide top-ups on salaries, to the current status where the top-ups are now drawn from the HTF as part of a wider incentive mechanism including other additional allowances for doctors and midwives, drug supplies and equipment.

"The government had said they were going to be able to support the health workforce, so it was under this that they were hoping the government will be able to pay its health workers by end of 2013. Realising that the Global Fund was moving out, we[MoHCC] went to the HTF and said can you come in and help and they agreed because Global Fund was removing 25% every year. The HTF agreed to pay the same amount to support the health workers until 2018. We are still trying to convince them to support us beyond 2018." (KII 012 National Health Manager)

"I think when it was introduced [retention allowance] it was trying to make sure that key people don't leave the institutions so that institutions would remain suffering, so we will then pay retention allowance to make sure that you stay where you are and provide the services but I am not sure whether people are still getting it [retention allowance]." (KII 009 National Health Manager Mission Sector)

"The HTF is supporting all the health workers in grades C5 and above. Probably the challenge that we have is that the paying agent is the same [as the harmonised retention] so people believe this is only coming from the harmonised retention because HTF is complimenting whatever government is doing. So they are also contributing to the support of all the health workers or retention of all health workers in grade C5 and above. I think it's important that people be made aware that whatever the partners are doing its complementing government efforts." (KII 013 National Health Manager)

The issue of the harmonisation is quite clear. We used to have targeted incentive schemes; it was problematic because those who were not getting the allowance would then leave most of the work to be done by those who were receiving it. Health issues and delivery is not for one person it is for the whole team. With the harmonised retention it is better because there has been an improvement in terms of performance of the whole institution. (KII 012 National Health Manager)

Municipal health providers

The municipalities are required by the urban councils and public health acts to provide primary health care services to residents in the cities and towns. The Ministries of Local Government and Health, which administer the two acts, interact on key issues with regards to the administration of health services in the municipalities. Each town or city has its own health department and health funding is dependent on the income from ratepayers and the services available in the city or town. In Zimbabwe rates are a special type of tax paid to municipalities for services rendered. There are several types of rates, which include residential, construction tax, reticulation, business operating licenses and road taxes. There are variations in the amounts that each municipality allocates for HRH retention and salaries based on revenues collected. During the crisis, revenue collection was very depressed leading to the adoption of further initiatives to increase available funds to meet health worker salaries as shown in the excerpts below. According to key informants, HRH in municipality employment is managed and remunerated independently by health departments. The municipalities have evolved a system that complies with most of the regulatory requirements as prescribed by the HSB with regards to health worker conditions of service like registration with health professions councils before appointment, and minimum qualifications.

“The municipality also requested from the Ministry of Local government and housing to be allowed to include all the HRH in the council’s own grading system in 2008. Previously the grading system for nurses and doctors was universal around the country and this meant that HRH would earn almost the same salaries in the health sector whether they were employed in the public or municipality sector. The strategy to include HRH grades in the municipality grades in 2008 allowed the municipality health workers to be slotted into higher grades with higher salaries. This was granted in the same year and nurses and health workers were regraded using the local government grading system.” (KII 002 Health manager District 1)

“...Extraordinary measures were taken to avert the total collapse of health delivery in the city’s health services department which included the decision to pay every worker of council one hundred South African rand without official Reserve bank permission starting in October 2008. We were able to do this because we were already billing the international transporters passing through the city in foreign currency and it is from this that we were able to sustain the foreign currency based wage bill.” (KII 014 District health manager)

“The municipalities build poly clinics and primary health care clinics in the localities of their jurisdiction and collect service fees from businesses and local denizens which are used to finance the recurrent budget for health as well as other services. In their health departments municipalities employ HRH like doctors, midwives, nurses, EHTs, EHOs and pharmacists. These HRH are not civil servants although the municipal facilities are classified as public sector health facilities. The MoHCW administers and superintends over the municipal health departments but with no direct influence on HRH issues. The recruitment and conditions of service of HRH in municipalities are the responsibility of the municipal councils not the HSB. However the health workers have to have all the legal paperwork that allow them to practice as prescribed by the various act on health.” (KII 002 Health manager District 1)

Regarding issues related to compensation and retention, a marked difference subsists between municipalities and the other sectors. According to key informants there has been a change in the conditions of service in the municipality sector which started around the late 1990s. While conditions of work were deteriorating in the public sector, particularly with regards to salaries, the municipality sector was increasing salaries and continuously reviewing conditions of service for health workers. Municipalities were able to recruit more skilled and more experienced staff as a result of their more attractive conditions of service during the crisis and after. This contrasts markedly with the pre- crisis period when most health workers shunned working in the municipalities according to a manager in the municipality. The rural district councils could have done the same. They did not utilise the local council grading facility, because they have little capacity to raise funding to finance salaries.

“From the early years of independence when the [Zimbabwean] public health sector was the envy of the Southern African Development Community, the municipalities were hard pressed to attract health workers as all health workers wanted to join the it [public sector] because then the conditions in the public sector were way ahead of those in council [municipality]. This has changed and this change occurred around the late 1990s as conditions began to deteriorate in the public sector. The municipality at this time was continuously reviewing conditions of service and as we entered the year 2000 the local municipality had become the most sought after employer by health workers across all cadres. You saw from the health worker profiles, we have highly qualified midwives here, better than at the provincial hospital and we recruited them from the government hospitals and you can also see that we have nurses, very old ones with SCN, these were recruited a long

time ago. These were the nurses that were leaving the public sector because they were looked down upon due to the SCN qualification that had been phased out. So at one point council could only attract such nurses instead of the RGNs and Midwives. We have retained these old nurses because they have been with us from the difficult days. And the low rating of municipal health departments began to change in the mid-1990s and we became an even more attractive employer during the crisis period. This has been maintained after the crisis as it is difficult to withdraw benefits once they have been awarded. So as employers of HRH municipalities will continue to offer better benefits than the public sector.” (KII 002 Health Manager district 1).

During the crisis period in 2007, the municipality in district one approved a 20% retention allowance to be paid to all health workers, making this an even more attractive place to work during the crisis. In addition, the municipality offered better salaries, regular working hours, and other fringe benefits, among them housing loans, subsidised water billing, medical insurance, funeral insurance, school fees for children and transport allowance.

“...in response to the deteriorating economic situation in the country [the municipality] went out of the way to help the situation so that it continued to retain those health workers within its system. At the height of the cash shortages the municipality put in place a system where health workers would be paid cash from the revenues collected. This ensured that all health workers got their salaries in cash without hassle.” (KII 002 Health Manager district 1)

Retention initiatives formulated during the crisis were quickly undermined in the hyperinflationary environment. Attempts to pay salaries within shorter intervals were difficult to sustain in the long term as the municipality also experienced a decline in revenue flows as rate payers failed to pay their rates due to cash unavailability. In the final analysis a more sustainable solution was to pay part of the salaries in foreign currency. In district two, some of the initiatives that were adopted were:

“To pay cash to the health workers and to pay salaries every two weeks to keep in line with inflation. This did not work because inflation was very high and eventually we decided to pay health workers a flat figure in South African Rand to cushion them in July 2008. This was illegal but had to be done and was possible because the municipality had also started charging parking and transit fees for trucks passing through in foreign currency because the local currency was now difficult to access in the market. Municipalities became the destination of choice for many of the HRH leaving the public sector.” (KII 014 Health manager district 2)

The key informants mentioned the current freeze on recruitment by the Ministry of Finance introduced in 2010 across the public sector, mission sector, municipalities and rural district councils. The executive council of the municipality complied with the government ban on recruitment. The key informant referred to the freeze as:

““skinning a skeleton”. Nurses retire, some die, some leave but they are not replaced but the expectation is that services should be as good as before. We have more patients every day in municipality as a result of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), Tuberculosis (TB), we should be allowed to recruit. There are vacancies in the clinics that cannot be filled because of the freeze. However if the freeze is lifted there would be no problem in attracting HRH to the municipality because of the attractive conditions of service on offer” (KII 002 Health manager district 1).

The mission sector

On attainment of independence, the Zimbabwe government adopted equity-centred policies in the health sector. This policy thrust, adopted in 1997, meant that all health facilities not directly controlled by government but serving the majority of people, like the mission sector, were asked to allow government to take over the recurrent expenditure responsibilities, especially payment of salaries of health workers, drugs and sundries procurement, infrastructure development and general maintenance.

“Mission buildings, equipment and everything belongs to the mission institutions and it’s not... even if government is putting money there government realises that the work of mission hospitals is complimentary because 70% of the population is rural and if we look at the population of mission hospitals they are the ones which are servicing the population in the rural areas. We constitute about 68% Health care delivery based on the bed capacity in the rural areas and nationally it is 35%, so we are the second largest health provider, so that relationship really needs to be complimentary; so government realises that if we invest a little bit in mission hospitals they are also bound to gain because the population will be serviced, it is the same people same Zimbabweans so there is no divisions to say these are mission hospitals and these are government.” (KII 009 National Health Manager Mission Sector)

The formalisation of a unified health service, which started in the first decade of independence, remains incomplete particularly with regards to the mission, rural district councils and urban municipal providers. There is no clarity on the working relationship between government and the mission sector. Prior to the crisis, the mission sector was more attractive with regards recruitment of

health workers. Funding was provided by the mission sector directly to the health facility. When the MoHCW took over the mission health sector, there were no clear policies, especially on how the mission workforce would relate with the HSB. Mission sector health workers view themselves as employees of the government, (see IDI Report Chirwa et al 2015a) yet the key informant who is a health manager in the mission sector asserts that:

“...Our role is to facilitate the smooth running of Mission hospitals but we don’t have the day to day administrative responsibility of running institutions; they are semi-autonomous. And Mission hospitals and clinics are owned by various churches falling under different denominations with majority of the hospitals, about 52% belonging to the Catholic churches, they are the ones who have more hospitals in the country. So in terms of that, when it comes to human resources for Mission hospitals, first of all Mission health workers are employees of churches and hence are not government employees.” (KII 009 National Health Manager Mission Sector)

Mission hospitals with nurse training attracted nurses, and this also worked to attract nurses to sister mission hospitals of the same faith that had no training schools. Nurses who trained at mission nurse training schools and were employed at mission health facilities were able to enrol for training more quickly. This was the case when the state certified nurse conversion programme (upgrading of SCN qualification to RGN) was taking place.

“...when training opportunities are offered like during the conversion of SCN to RGN nurses from ... and ...other sister churches were offered places for upgrading if they had enough O’levels. So all the nurses with SCN were able to upgrade due to this preferential opportunity. Those that did not upgrade did not have O’levels or they had commitments...” (KII 011 District Health manager district 3)

The mission hospitals also benefitted directly from the training schools that they administered and owned by retaining graduates from the training school in their workforce. This made them retain some of the best health workers who also were assured of career progression through post basic training at the numerous mission owned training schools

“...because we are training for national absorption, so then the Ministry will then say, so many will go there, maybe go to Nkayi or wherever and then a few will remain with the training institutions if they have the vacancy but because of the freeze sometimes it becomes a nightmare. But over the years those mission hospitals with nurse training schools have had this advantage of retaining some graduates.” (KII 009 National Health Manager Mission Sector)

The general perception among key informants was that the mission sector has become unattractive after the economic crisis and the takeover of health institutions by government. Grants from government are erratic and inadequate and this has led to a decline in standards with respect to working conditions as well as health infrastructure.

“Before the crisis the mission sector was the place to work, with subsidised accommodation attracting nurses from surrounding public sector hospitals and health facilities. When the government took over the management of the hospitals the missionaries stopped any further development and as a result in the last ten years [2002-2012] accommodation has become a problem and health workers are staying in crowded conditions. The government has not developed infrastructure and the mission facilities are now facing challenges. What has worsened the situation after the crisis is that mission health facilities attract people [patients] from beyond their catchment area because patients believe that the services are better at mission facilities than in public sector facilities. The crisis has made almost all nurses to desire post basic qualifications as this is seen as a means to get work in high paying sectors or regionally and internationally. It is now hard for nurses from the mission sector to get enrolled at the post basic training schools most of which are at public health facilities. This has seen many nurses now trying to transfer to public sector health facilities.” (KII 011 Health manager district 3).

According to one health manager at the national level salary differentials between cadres in the public sector and mission sector is a major point of disgruntlement as some workers in the mission sector feel they are being discriminated against. Their salaries are determined by the grant that government provides and if they have attained a higher grade they have to resign from the mission sector and get a post in the public sector where that particular grade is tenable. This is not understood by health workers because of lack of information regarding the contractual position regarding health workers in the mission sector.

“Cadres in the mission sector are paid through grants which are not really salaries, it’s a grant and the grant determines what goes towards payment of health workers, so within that grant there will be 100% which goes towards the salaries of the establishment approved by government based on salary bills approved by government not by churches... there are certain allowances which are given to a government employee but not so much to eehh Mission hospital because of the grant limitations... that we also get a grant for recurrent expenditure that is not going to institutions, so you would find out that a hospital will get maybe \$4 000.00 per month or three months

to run an institution, there is nothing you can do because you have a bill for electricity, for water, you have to feed patients; laundry, you have to buy drugs.” (KII 009 National Health Manager Mission Sector)

“Health worker grades for cadres, particularly nurses with the same qualifications, are different for cadres. Salaries of cadres in the same grade are not comparable between public and mission sector. This difference is a result of the grant system referred to above....the salaries we are getting here are different from what our juniors in the government are earning. I am still at grade D4 but I am supposed to be at grade E2. We have tried to send papers to the PMD highlighting those issues but we were just told that everything has been frozen.” (KII 011 Health manager district 3).

Another key informant stated that:

“The grading is now different from the public sector and this happened after the crisis, Individuals with similar training, work experience and working at similar health facilities in terms of the levels of care provided are in grade D4 while in the mission sector there are in grade D3. This happened in 2009 after dollarization. Letters were written to the appropriate authority to correct the anomaly in 2010 but in 2013 we still have not received a response. The aspect of locum is also bothering us because we are not benefiting from locum but we know in the public sector people started doing locum work in 2012 but in the mission sector we only started in 2013. At present we have not received payment of locum work and we do not know what rate is going to apply.” (KII 010 Health manager district 2).

A health manager responsible for HR from district two referred to letters written in 2010 to the Salaries Services Bureau (SSB) and MoHCW Head Office requesting that the grading anomalies be resolved. Since then there has been no response or resolution of the grading anomalies. On further probing as to why it seemed so difficult to resolve such a simple matter, this key informant stated that:

“I am not sure what the problem is but as an HR specialist I want to link the freeze in recruitment with this failure to realign grades in the sector. We also have people who were promoted in 2012 but they are working in their new capacity following the promotion but they have not received the salary that go with the current post. The aspect of correcting grades as well as promotions will have financial implications and hence this may need treasury concurrence and since this is a problem that was created administratively immediately after the crisis no one is able to deal with this. Remember, before dollarization in January

and February 2009,.... is it up to March ...I cannot remember..., everyone in the public sector received a \$100 voucher as salary whatever grade one was at. When salaries were pegged in United States dollars there were challenges and I am sure the grades were mixed up then. I am sure when the MOHCW and SSB get money they will correct these anomalies.” (KII 010 Health manager district 2).

A second key informant said:

“...pensions are not being paid to the retiring members. Since the adoption of the multi-currency regime in 2009 we have had no pensions deducted and the Zimbabwe Association of Church related Hospitals (ZACH), who are responsible for our conditions of service, have not been forthcoming with explanations on these challenges. We have had members who have resigned and have not received anything in the form of pensions. We sought to gain further information on the issue regarding pensions from the ZACH but this proved difficult and we conclude that this is a very sensitive issue politically as many people were affected.” (KII 011 Health manager District 3).

Specific policies on retention in the mission sector were not mentioned in the interviews. However, references to benefits that accrued to health workers from the missionary society were made. These included access to schools, negotiated payment of school fees, subsidised accommodation (which has become overcrowded since the takeover of facilities by government) and preferential access to upgrading courses if employed at a mission health facility with a training school.

The private sector

The private sector suffered huge setbacks during the crisis and had to take drastic measures, which included retrenchment of health workers and other support staff. In order to continue providing services the private institutions resorted to HRH who were willing to provide services on a part time basis. Some of the HRH were from the public sector. At a private hospital in district one we were able to interview one informant - the only full time employee who is a health worker. The rest of the full time employees are support staff. The administrator asserted that the private for profit sector had been hit hard by the crisis.

“We were forced to cut down some of the things we used to do, for example the workforce was reduced from 24 to 10. We used to have a cleaning department with three people and we have only one person, we also used to have a fully functional accounts department but now we are left with 1 person. Computers broke down and we could not repair them and our X-ray broke down and we failed to replace it up to now. We used to have

credit terms with the [traditional pharmaceutical companies] buying our drugs locally but now these companies broke down so we are now buying from the indigenous people who are importing from South Africa and the drugs are expensive we cannot stock... Instead all nurses at the facility were now coming on temporary contracts on a locum basis. These nurses work in other institutions in the district in the mission and public sector. This applies for the doctors too... The hospital has its own rules with regards recruitment and these were simply that health workers should be registered to practice. The remuneration is largely based on the experience of the health worker and the payment rates are better than those offered in the public sector... a lot of health workers were seeking opportunities to work at this private hospital. We employ very experienced health workers especially the nurses. The doctors are less experienced due to the general shortage of highly experienced medical officers due to outward migration but we provide an exceptional service as you can see the number of patients we are receiving.” (KII 003 Health manager Private sector District 1)

The doctor interviewed at the private hospital acknowledged that the private for profit health sector had become a source of competitively rewarding part time employment for all health workers. A doctor who agreed to be an informant stated that:

“I am a fulltime medical officer in the public sector and I am doing private work at this private health facility on part time basis. There are more than eight doctors that work part time at this particular private health facility who all work full time in the public health sector...The rules on private practice cannot be enforced in a situation of depressed salaries. This would create more strident demands for improved working conditions by public sector health workers...” (KII 015 Health manager Private sector District 1)

Key informants in all districts were reluctant to discuss private practice but acknowledged that health workers in the public, mission and rural district councils were doing extra work to augment low salaries. Such private practice is being done at times in violation of the private practice policies. The data we got from the few key informants points to a situation where the authorities do not reprimand health workers doing private practice even despite being ineligible to do it.

A health manager we encountered at a private hospital but who works in the public sector said:

“Rules on private practice were not being followed because the salaries in the public sector were unrealistically low especially during the difficult times. This has made doctors and nurses in the public

health sector to be innovative and a lot of the doctors were doing some form of private practice and there is nothing anyone can do about it. Although now, compared to the period 2007 and 2008, there is some improvement, health workers continue with private work and the question of whether this is sanctioned or not does not arise because the salaries are very low. Young doctors are eager to do private practice in the private hospitals because of better resources and equipment which helps them gain experience. It is folly to spend time policing a regulation which in fact is being broken to provide a service that is essential. People have lost confidence with the public health institutions and would rather spend more money getting more efficient services at private institutions. We have nurses who do private practice at private hospitals and clinics well beyond the prescribed period for locum because salaries are low. So those supposed to enforce the regulations are not so eager to do anything about flouting of regulations on private practice because they will lose such people and these are very experienced people.” (KII 015 Health manager Private sector District 1)

“...As long as such private work is done without prejudice to the health institutions there was no sanction that would ensue. There are some private nursing homes that are operating although most of them are supposed to have doctor as part of the team that is not always the case.....” (KII 015 Health manager Private sector District 1)

Drivers of change

The key actors in change processes according to key informants are the government, and development partners. During the crisis changes in policy were a result of the cooperation of the government, Department for International Development United Kingdom, World Health Organisation (WHO), Global Fund (GF) and the European Union (EU).

“Normally Global Fund does not support salaries in any way so it was a special request by the Ministry to Global Fund or even to the HTF now that they support so that if people deliver, their salaries will be provided for and they agreed in the hope that the government will improve salaries and they are hoping they will be able to support its workers.” (KII 012 National Health Manager)

“... during the crisis particularly in 2007 when the health sector was almost collapsing these development partners influenced government to adopt policies that sustained HRH supply in some of the most disadvantaged provinces and districts. Government allowed health workers to be paid directly by development partners in foreign currency in selected districts.” (KII 022 Development partner)

International and regional agreements and conventions on health, which the government is a signatory to, are important drivers of change according to key informants.

“Zimbabwe is a signatory to regional and international protocols that shape the policy direction then we take in terms of human resources for health. We also have a human resources for health observatory. Regionally we have the southern African health protocol and through this we have tried as a region to come up with a concerted effort to curb the flight of health workers by putting in place a system of ensuring that health workers do not get employed in the region without the prior consent of the source country... so you see we have now stemmed the exodus to South Africa and Botswana through this arrangement and through this arrangement we have also been able to strengthen the bonding of our health workers...” (KII 013 National Health Manager)

The Ministers of Health, Public and Social Services and Finance are also key people in driving change because some of the HRH issues that need addressing require that these Ministries concede to the changes being envisaged.

“...policy fluxes like the health workers’ duty free importation of vehicles which are now in abeyance, is a reflection of lack of fiscal space to provide funds by treasury (MoF) to HSB. ... failure to maintain the 2007 increases to health worker allowances ... is a function of fiscal protection ... the PSC is supportive of any initiative by HSB and the MoHCC towards health system strengthening through adequate HRH supply but not at the detriment of other government departments.” (KII 018 Public sector manager).

The question of making the health sector different from all other civil service sectors is particularly viewed as a reversal of harmonisation of the public sector reform agenda embarked on by the PSC in 2005. This implies that for the HSB to succeed in changing the HRH policy a key player in any policy change agenda is the PSC.

The government service is not divisible and no single department or ministry can decide to be treated differently if you study the public service regulations that is made very clear so the health service will always be part of the civil service and the PSC will monitor the MOHCW (KII 018 Public sector manager).

The MoHCC and HSB asserted that evidence is a key aspect that drives policy change in the health sector.

The Presidential Review Commission of 1999 led to the formulation of important policy agendas, the HSB was born out of the findings of the commission and the decentralised hospital management boards as well as the community or village health committees...

Assessments and situational analyses have led to changes in policy indicating that evidence can sometimes be a factor in policy change. The 2008 HRH situational analysis informed the formulation of the harmonised retention allowance policy. (KII 017 National Health Manager)

Funding availability is another important driver of change. According to key informants, the acceptance by government to allow health workers remuneration to be paid by development partners shows that funding may facilitate policy change.

“Normally Global Fund does not support salaries in any way so it was a special request by the Ministry to Global Fund or even to the HTF now that they support so that if people deliver, their salaries will be provided for and they agreed in the hope that the government will improve salaries and they are hoping they will be able to support its workers. The government had said they were going to be able to support its own workforce, so it was under this that they were hoping the government will be able to pay its civil servants buy end of 2013. Realising that the Global Fund was moving out, we went to the HTF and said can you come in and help and they agreed because Global Fund was removing 25% every year. The HTF agreed to pay the same amount to support the health workers until 2018. We are still trying to convince them to support us beyond 2018.” (KII 012 National Health Manager)

“The Vital Health Services Support Programme (VHSSP) in 2007, the harmonised retention scheme in 2009 and the Health Transition Fund (HTF) in 2012 are examples of change in policy caused by funding contributed by development partners. The VHSSP initially introduced in 2007 to assist poorly performing districts at the height of the crisis in selected districts, and later the harmonised retention scheme and the HTF in the post crisis period were critical interventions which would never have seen the light of day had it not been for the fact that the development partners had funding to kick start the interventions. These two programmes required that health workers sign service contracts that were linked to defined performance standards and these contracts were in addition to the ones they had initially signed on appointment in the service.” (KII 022 Development partner).

The factors which drive policy include the relative importance of different constituencies. Health workers in rural areas believe that they are not benefitting in equal measure with respect to the duty free importation of vehicle initiative. The duty free importation of vehicles for some categories of health workers was viewed as being pro-urban by a facility manager interviewed at a rural hospital who said:

“Duty free importation of vehicles for civil servants was once introduced and I was very happy because I managed to buy my car because of my grade and the fact that I am the sister in charge here, and because of that I will not leave my job. But the other junior nurses here in rural facilities are far from getting this benefit because they are very junior and they disgruntled and this makes managing them difficult. Duty free importation of vehicles should be for every health worker so that no one feels excluded.” (KII 021 Health Manager District 3).

Economic changes

The macroeconomic situation in Zimbabwe deteriorated at an unprecedented rate and to severe levels between 2007 and 2008. During this economic meltdown a sharp increase in health worker migration from the country occurred. The exodus reached a level where the public health sector, according to one key informant, *“became so dislocated that it was difficult to refer to it as a health service at all in some areas of the country”*.

The severe economic, social and political crisis affected health workers in a variety of ways and was cited as the reason why health workers decided to leave their work places, particularly in the public sector and mission sector. It is also important to note that the severe crisis elicited varying responses from the various health service providers.

The major challenge that affected all health workers across the providers was that the salaries were eroding so fast. Furthermore, the difficulty to access money from the banks dampened health worker motivation service wide. When employees earn little and are also unable to access the little that they are earning, like was the case for the public and mission sectors, it becomes difficult to retain those workers. This was the situation in the health sector in all the three districts in 2007 at the height of the crisis.

Key informants said the initiatives to improve salaries and other allowances in January 2007 were dishonest and were meant to hoodwink health workers. A key informant in district three stated that:

“The increases that were effected in January 2007 were never useful to anyone particularly here in the rural areas where we had only two banks at the local service centre. The limit on withdrawal amounts meant that we never benefited from the increment until the rationalisation of civil service salaries in May of the same year.” (KII 011 Health manager district 3).

The decline in standards of living in the country for everyone including health workers has been there for a while and it will be a challenge to come up with a solution to this as almost every health worker now believes that their living standards can only be changed by leaving the

public sector.

“Aaaaah [Health directors in some municipalities] get about \$1 500 but what I know is they are usually one and half more than the government... This is the cause of internal migration, usually we [government] train the health workers and they gain experience and they move to local authorities but what do we do?... It is issues to do with bread and butter. They [Health workers] maybe single mothers who are taking care of their own children and do you think they will stay where they will continue getting \$400 or they will go where they can get \$1500 ...I think we have money in Zimbabwe but it is how we use the money.” (KII 012 National Health Manager)

This perception that the public health sector is not attractive is very common, and participants from the three districts never described working for the public health sector as satisfying. The idea that the public sector is not an ideal place to work is entrenched but almost every older health worker interviewed mentioned that they were not moving from the public sector because of the pension. Were it not for the pension most of them indicated that they would have left. (See IDI Report)

The sentiment on pensions was shared by health workers in the mission sector and a key informant stated that:

“There are certain benefits like pensions which are still a sticky issue with us mission.” (KII 010 Health manager district 2)

The value that health workers attach to pensions is best understood by the historical effort at national level to come up with a homogeneous pension scheme for all the different mission providers. A National Health Manager outlined the effort that went into coming up with a pension for mission health workers:

“So the health workers then said we are being short changed, we are going home poor, penniless; if I have my money or cheque for \$100.00 and that’s what I get and that’s it and I am forgotten, so I end up a pauper; automatically when I leave the office I am done or when I leave the hospital I am done... because churches could not pay the employer’s part of the pension... we negotiated with the Ministry to pay employer’s part of the pension through the grant from government... the Ministry accepted to include pensions in the grant because as the mission sector we were helping health workers because of the role they are playing in delivering services to the rural communities...” (KII 009 National Health Manager Mission Sector)

Health workers’ felt let down they were unable to access their salaries. However, the municipality providers made an arrangement to pay health workers money from

revenue collected from rate payers.

The Environmental Health Practitioners Council (EHPC) observed that the economic crisis had an impact on the supply of environmental health practitioners. One participant made an observation that environmental health practitioners do not have a ready market outside national borders, unlike nurses, midwives and doctors. They are absorbed internally by other organisations that require their services, such as industry. If environmental health practitioners were lost from the public sector and mainstream health practice, they were being absorbed by industry within the country. The incentives and working conditions are much better than the public sector. It is difficult to account for environmental health practitioners as they register voluntarily to the EPH. Those working as safety officers in industry do not register because registration is not required, unlike for those working for the public sector and municipalities.

One participant from the EHPC pointed out that the health service delivery system deteriorated severely as a result of the economic downturn. The morale among staff was very low and led to Environmental Health Technicians (EHTs)¹ and Environmental Health Officers (EHOs)² not registering with the Council and general defaulting on annual registration renewals. As a result, it was not clear how many EHTs and EHOs remained working in the public sector. Reasons for this were erosion of the local currency, which made it very difficult to access their salaries from the banks as well as the unaffordable registration fees.

“In 2009 after dollarization “people were now able to come to work and were a bit motivated at work and as a council we saw a marked increase in the number of environmental health practitioners beginning to register as well as renewing their membership”. The incentive environment was changing and members were once more coming to register.” (KII 016 Health professions manager).

Changes to the political and security situation

The socio-economic crisis in Zimbabwe did not engender armed conflict and as a result key informants were not aware of or did not want to discuss any security threats that affected the operations of the health facilities and health workers. However, there was general acknowledgement that the political situation was characterised by a lot of polarisation, which in some

instances affected decision-making, particularly in the municipalities after 2009.

“...we heard that health staff had been harassed in 2008 but this could not be verified. Most of the harassment did not happen at the work place but in the residential areas we heard that this was happening.” (KII 002 Health Manager district 1”).

The formation of the new coalition government as a result of the Global Political Agreement (GPA) brokered by the Southern African Development Community (SADC) on 15 September 2008 brought about a semblance of normalcy and this began to restore confidence in the health sector.

“The unity government changed a lot of things and cadres in the health sector began to feel confident and the introduction of the United States dollar improved the economic condition of health workers. As you know most of the health workers were in the country doing whatever could sustain them. The worst thing that happened during the crisis is that cadres could not access their salaries so no one could blame them for not coming to work because in reality these cadres were working for nothing.” (KII 011 Health manager district 3).

International context

There were significant changes in the relationship with development partners after the crisis. Before the crisis and immediately after independence international development partners were central players in Zimbabwe's health sector both financially and technically. From 2000, international development partners and bilateral and multi-lateral players fell out with the government and gradually began to reduce financial support to the health sector. Instead of direct support to government, donors opted to channel financial support through implementing partners and other pooled funding mechanisms. An example was the Vital Health Services Support Programme (VHSSP), funded by the European Union (EU) and the Global Fund (GF), which was instituted in September 2007 in 3 districts in each of the 8 provinces that paid incentives through the district health fund.

According to key informants the VHSSP provided material inputs (vehicles, equipment, building renovations) as well as allowances to an average of 7-8 members of the District Health Executive in each of the districts where it was being implemented. The selection of the districts was based on need. When asked whether the VHSSP

¹ Environmental health Technicians complete a three-year diploma. They provide preventive services for communicable and non-communicable diseases in the communities. Their work includes inspection of food dispensing facilities to ensure that they are compliant with public health requirements, they educate and are involved in public health preventive activities like disinfecting homes to reduce mosquito populations, ensuring proper disposal of refuse, pesticide containers, proper methods of burial of the dead, inspecting abattoirs and butcheries. The EHT is also the entry grade for health staff who have completed the diploma and they will progress within that grade to the highest level of Principal Technician.

² Environmental Health Officers complete a degree in Environmental Health and supervise the work of EHTs.

was still being implemented, the key informant was unable to give a definitive response.

The political settlement in 2009 brought with it a sense of economic stability and international cooperation. Key informants acknowledge that the formation of the coalition government brought about changes in the relationship between the donor community and the government. The coalition government facilitated cordial relations which saw the injection of funding towards re-attracting health workers to health facilities in rural areas. Key informants noted that the introduction of the donor-supported harmonised retention allowance in March 2009 marked the beginning of a process to improve the distribution of health workers. The normalisation of staffing levels was a major achievement of the coalition government which happened on the backdrop of improved funding streams from the international donor community. However KII noted that the donors continued to mistrust government, channelling the funds for various programmes through independent private companies. The harmonised retention fund was being managed by Crowne agents and participants said this was done to improve accountability.

Policy implementation challenges

The socio- economic crisis, according to all key informants, was most severe between the years 2005 and 2008. The HSB and PSC noted that the socioeconomic crisis was a cumulative one that went back to the early years of Zimbabwe's independence. Policies that were adopted at independence were not sustainable in that they were made to address questions of equitable health delivery without addressing the issue of resources to sustain the reforms of the health sector. The issue of HRH remuneration was never addressed systematically and hence what happened from 2000 onwards with regards to HRH flight and disaffection was the culmination of years of inaction with regards to well-known problems with HRH conditions of service.

The HSB

The creation of the HSB in 2005 was a major policy change and was seen as a huge step towards achieving the elusive goal of strengthening HRH management and planning. From the time of its creation, the HSB faced challenges because the separation of responsibilities between the HSB and PSC was not clearly defined. Key informants described the relationship of the HSB and PSC as follows:

“You will find that the Public Service’s interest is coming from the Zimbabwean member of the public interest. The Health Service Board is the employer of health workers and when they monitor through their structures it is an interest in terms of first-hand information on how health services are provided...”
(KII 013 National Health Manager)

“We do not know who is achieving the greater good for health workers between the PSC and the HSB. As an administrator we are subject to periodic reviews by both the PSC and HSB. They come and ask us the same questions and review the same files and at the end of these reviews we do not know whether they share these reports. My own view is that the HSB is subservient to the PSC and it is better that money is saved by removing one of them” (KII 021 Health Manager district 3).

The HSB was able to secure consensus on salary differences between the health service and the general civil service in recognition of the uniqueness of the health sector. This lasted three months after which the policy was reversed. Key informants pointed out that implementation of the Health Service Act had been challenging because some components of the Act were not acceptable to other ministries. The discrimination that results from the preferential treatment of the health service is unacceptable. According to key informants, the challenge is if the HSB is given wide powers to determine salaries for health workers then all other sectors would demand similar treatment.

An example of the inter-ministry rivalry that has dogged the HSB and made implementation of progressive policies difficult is when the HSB increased medical allowances from 20% to 300% of basic pay in January 2007. The increases were reviewed downwards to 70% of basic pay in May 2007. On-call allowances which were increased from 24.5% to 200% of basic pay were reviewed downwards to 135% of basic pay, as was the post-basic allowances to midwives and nurses which were introduced in January 2007. Post-basic allowances to nurses were paid at a rate of 100% of basic pay per qualification for up to 2 qualifications when they were first introduced but were subsequently reviewed downwards to 67.5% of basic pay per qualification.

The increase in basic salaries for health workers was less than for the wider civil service so that the health sector salaries which had been changed could be harmonised with the other civil service salaries. The reduction in remuneration levels and incentives for the public health service was more acceptable politically. Maintaining the health service benefit structure as it was would have caused a corresponding increase in the wider civil service benefits to match the health service longer term. The other reason why some of these policies were reviewed downward was that there was no funding for the allowances.

“... there was an imbalance in the proportion of the budget going towards the wage bill for health workers and that going towards financing health care services. The HRH budget was so huge and unsustainable in an economy in decline. These factors caused health worker disaffection” (KII 022 Development partner).

The duty free importation of vehicles

The policy of duty free importation of personal vehicles for health workers, which was briefly introduced during the crisis, has not been implemented widely. Post-crisis, there has not been a single beneficiary nationwide. Participants stated that this policy is still in force but implementation is being hampered by failure to allocate funding. One key informant in a rural district said:

“In terms of written policies the MoHCW is the best place that one would want to work. A lot of good policies are in place but they are not benefiting health workers in rural areas because there is this understanding by policy implementers at head office that rural health workers are not as troublesome as the urban based health workers. An example is that in the whole district only one nursing sister was able to benefit from the duty free vehicle importation scheme. The DNO, the district medical officer and district environmental officer never benefited despite having applied” (KII 017 Health manager district 3).

The Harmonised Retention Scheme and other financial incentives

All key informants acknowledged that the retention scheme that was introduced in 2009 was a very important development. It led to tangible improvements in health worker performance as measured by attendance at work. There was some dissent on some aspects of the retention scheme which key informants said made the retention scheme detrimental to the wider effectiveness of the public health service. The first was the selective nature of the retention allowance with regards to beneficiaries. The second aspect was the phased reduction of 25% per year until 2013 when the retention allowance would cease.

Some of the HRH in grade C4 and below were not happy because they were excluded from the retention scheme. The rationale behind their exclusion was that HRH below grade C4 were very unlikely to leave for greener pastures. Key informants who were managers at head office and facility managers observed that while the decision to exclude the grade C4 and below made a lot of financial and economic sense, it also created a lot of human resource management problems at all levels of service delivery. Most of the excluded HRH in this grade do work that looks unimportant but is critical in health service delivery. One key informant noted that:

“Motivating auxiliary staff especially was now a serious problem because of their exclusion from the retention scheme. Cleaners take time to clean up during and after delivery. Some of the deliveries end up being done in rooms that have not been cleaned. Further problems are being created by their exclusion in the recently introduced neo- natal and

maternal services allowance being paid to midwives through the Health Transition fund (HTF)” (KII 020 Health manager district 2).

However, the participant was unsure of what the HTF was all about. The key informant stated that,

“HTF is an allowance to be paid to all health workers with maternal and neo-natal qualifications commonly referred to as midwifery. At the time of the interviews the retention allowance had not yet been implemented” (KII 020 Health manager district 2).

The HTF “is a mechanism to help all health workers involved in reproductive and maternal health services earn better salaries to improve health outcomes for mothers and children. This is to help in reducing maternal and infant mortality which are now high”. The HTF is a multi-donor fund supported by DFID, Global Fund and the European Union introduced in 2012 (MoHCW, 2011).

The phased reduction of 25% of the harmonised retention allowance was another issue that bothered health workers. Key informants at the national level provincial and district levels observed that there was little information available on what would happen when the retention scheme was terminated in 2013³. Key informants from the MoHCW and HSB stated that increments from the government in 2010 improved salaries but the increases were way below what the retention allowance added. Participants said that problems experienced during the crisis, such as absenteeism, were likely to recur if salaries of HRH remain at current levels. A manager in the public sector said,

“During the crisis there were many cases of indiscipline and junior health workers were stubborn and could not be managed. When gave instructions they would not take kindly to that and would take time to act on the instructions. We used to tell them that they would be charged for not working according to the contract they signed up to but they would not mind. They argued that there was no difference between a job at the hospital and staying at home. There was a huge change when we were told that a retention allowance was to be introduced and that managers would complete attendance returns for all health workers under their supervision every month to HSB for payment of the allowance.” (KII 020 Health manager district 2).

A participant working at national level showed there was little dissemination of information about changes in policy. The harmonised retention has been replaced by the HTF. This change from the harmonised retention to the HTF taking over the financing of the incentives for health

³ The quantum of the retention allowance is not known following the 25% reduction.

workers in grade C5 and above had not been explained to health workers and regional level managers.

“It was an agreement that as Global Fund withdraws HTF will come in... These people do not really understand... So people are not quite clear [on the harmonised retention and the link with HTF]” (KII 012 National Health manager)

Health workers in grade C5 and above still believed that their top-ups are still mediated by the harmonised retention allowance policy 2009. Poor and untimely dissemination of policy provisions bred mistrust between those health workers receiving extra direct financial benefits from the HTF and those that did not.

“[This] fund [HTF] will benefit those institutions which have been identified and targeted, so not every institution is going to get it, so what happens now is that these people are the midwives, Aaaaah it’s more like a fund which incentivises a site to do better and addressand it’s like performance related and then the more you do better the more resources you get. So you find that those institutions there can actually improve their facility and also improve whatever, buy fuel for your ambulances and so forth, so as to improve service and then the staff at that institution are also given incentives; so that’s where the bone of contention is that this incentive is not across the board so others are enjoying certain benefits yet we are in the same system. So that’s how people think it’s unfair because most of them wanted to come in but if funds are available it will expand to other institutions.” (KII 009 National Health Manager Mission Sector)

“The HTF is supporting all the health workers in grades C5 and above. Probably the challenge that we have is that the paying agent is the same so people believe this is only coming from the harmonised retention because HTF is complimenting whatever government is doing. So they are also contributing to the support of all the health workers or retention of all health workers in grade C5 and above. I think it’s important that people be made aware that whatever that the partners are doing its complementing government efforts” (KII 013 National Health manager)

“Ummm normally Global Fund does not support salaries in any way so it was a special request by the Ministry to Global Fund or even to the HTF now that they support so that if people deliver, their salaries will be provided for and they agreed in the hope that the government will improve salaries and they are hoping they will be able to support its workers. The government had said they were going to be able to support its own workforce, so it was under this that they were hoping the government will be able to pay its civil servants buy end of 2013. Realising that the

Global Fund was moving out, we went to the HTF and said can you come in and help and they agreed because Global Fund was removing 25% every year. The HTF agreed to pay the same amount to support the health workers until 2018. We are still trying to convince them to support us beyond 2018.” (KII 009 National Health Manager Mission Sector)

The level of misunderstanding of the HTF is demonstrated by the different interpretations of the HTF’s scope of activities. The question of who benefits is not clear although there is some acknowledgement that the HTF has improved the distribution of doctors. However, there are undercurrents of dissatisfaction with regards the selective nature of the HTF according to the provincial manager interviewed:

“I know for doctors, there is HTF [Health Transition Fund]. For all other health care workers there is nothing or if there it is miniature. For doctors it’s substantive, to the extent that we now have some doctors in rural areas, the package is better but nurses do not have that. The specialised nurses covered by HTF are midwives only and these will be working at main hospitals only, this is not fair because midwives and nurses at clinics and in remote areas do not get the allowance. There is nothing to motivate them. We have retention allowance for all health workers but it’s nothing to write home about.” (KII 020 Health manager District 2)

Retention allowances for health workers in municipalities

Personal to Holder allowance

In the municipality in district one, we encountered other retention schemes. HRH were being paid 20% of their salary monthly as a retention or critical allowance which is called ‘personal to holder’ allowance. This retention model was introduced during the crisis. It benefited health workers across the board, including nurses (SCNs, RGNs), doctors and environmental health professionals (EHTs/EHOs). The personal to holder allowance is not time bound and is paid to deserving cadres for as long as they remain employed in the municipality. This allowance is paid to health workers who remained in employment during the crisis but those health workers that absconded during the crisis or those that were recruited after the crisis are not eligible. According to the key informant from the municipality:

“Nurses were given 20% of their salary as a retention or critical allowance which is called personal to holder allowance to retain them and cushion them against the vicious economic situation prevailing in 2007. This is still given to those that were there during the critical period because once you give an allowance you cannot remove it” (KII 002 Health Manager district 1).

This has become a source of disgruntlement, according to municipal health facility managers.

“There is polarisation among those health workers who joined before the crisis and those that joined after. They do not work well together, as those that came after the crisis, and may have better experience and qualifications - earn less than those who remained in their posts during the crisis.” (KII 002 Health Manager district 1).

However, a key informant from the HR department in the municipality observed that new health workers are aware why this allowance cannot be paid to them. Most of them joined from the public sector where salaries were way below those paid by the municipality.

“They cannot afford to go back to the public sector and because our disciplinary processes are effective we do not have serious problems as a result of this selective retention allowance. During the selection process for we explain to applicants that they will find this arrangement at the facility that they will be deployed to.” (KII 002 Health Manager district 1).

Professional Allowance

The professional allowance is an allowance that is paid to all municipal health workers in district one and was introduced in 2008 to motivate health workers to stay employed with the council. This allowance is an additional 20% of basic salary. This allowance is still paid to health workers in the post-crisis period even those that were employed after the crisis.

Elderly allowance

The elderly allowance paid to health workers who are 60 or over, and is paid for the five years until retirement at age 65. It is an allowance that is meant to acknowledge their commitment to the municipality. According to one key informant, health workers are very supportive of this allowance.

RDCs in district two and three have not put any comparable incentives for health workers in place. HRH working in the RDCs get salaries and retention allowances from government and hence earn typical government salaries. This puts the HRH working in RDCs on edge as they complain that this is depriving them of a better remuneration. Less qualified local council (non-health) workers in the RDCs earn much better than nurses and this seems unfair to health workers, who are not employed on local authority grades.

Private sector

Little information was gathered on incentives in the private sector. We interviewed an administrator in district two but they did not divulge any information about remuneration.

Mission sector

All key informants acknowledged that there were no specific retention allowances paid directly by mission authorities to health workers working in the mission sector. This is because of the understanding that salaries and conditions of service are now the responsibility of the government through the HSB and the MOHCW.

Effects of the policy changes

The health sector in Zimbabwe functioned efficiently since independence. While health worker distribution was not equitable between rural and urban areas, a lot of improvements in bridging the inequities of health workers' distribution were made in the first decade of independence. However, the onset of the socioeconomic crisis led to a drastic reversal of gains that had been made and critical health indicators - mortality, crude death rates, morbidity and under five malnutrition - deteriorated.

“At independence health services were expanded and gains were made on all indicators, mortality, crude death rate and under nutrition improved from what they were before independence. Distances to clinics were reduced and more people who did not have access to health services were put into the loop. So improved access to health services was behind this success and when the crisis set in all these were affected and they continue to be affected due to the meagre resources being provided for health services by government.” (KII 017 National Health manager).

The creation of the HSB raised hope among health workers. The expectation that health worker issues were going to be handled by a specialised institution made up of health workers was appreciated. Key informants acknowledge that past initiatives by the Public Service Commission (PSC) had not worked and the HSB was seen as the solution to implement initiatives that address health worker needs. However, the HSB was not able to improve the situation of HRH and there was little impact on recruitment and retention. Resignations from the public sector increased around the time the HSB was created. The reason being the poor salaries offered in the public sector continued to subsist even after the creation of the HSB. The HSB was not strengthened at the time of its creation and most of the obstacles that existed before continued to cause problems. The crisis also affected the implementation of HSB initiatives especially those that needed financial resources, which would then require budgetary approval.

In the immediate term the HSB did not stem the attrition of health workers. Recruitment of nurses, doctors and environmental health professionals improved after the introduction of the harmonised retention scheme in 2009. The attempt by the HSB to raise salaries of health workers and to introduce allowances to keep health

workers in their posts was welcomed and improved motivation. However the reversal on some of these achievements has led to gradual loss of confidence with the HSB.

The HSB has heightened tensions across the public sector and this has seen the initiatives of the HSB being stopped after short implementation periods. The HSB has become an appendage of the public service, which is a problem because although the HSB would want to change the situation of health workers, the PSC has to sanction such changes. Informants said health workers are increasingly getting impatient and renewed migration from the public health sector has started to manifest itself.

Across the three districts all key informants from the public sector observed that the policies that have been adopted by the HSB, MoHCW and government have not yielded the change that would reverse the tide of high attrition. This is because that there were challenges in procuring financial resources for implementation. The HSB noted that all initiatives were nullified by high inflation, lack of financial resources and the difficulty of getting approval from PSC.

Municipalities reported that economic challenges during the crisis also affected their ability to collect revenues as rate payers failed to get money in the banks and this affected cash flows into municipality coffers. In addition to these challenges, some politicians also made statements that made rate payers deliberately withhold their payment of service bills.

“The maturity of politicians leaves a lot to be desired. Councillors tell residents not to pay their rates to gain political mileage because of the dire economic situation that ratepayers find themselves in but they expect to get very high allowances from council”. (KII 002 Health Manager district 1)

“During the crisis there were these political contradictions that affected municipalities’ ability to provide critical services. Reduced revenue flows meant that there was a challenge to meet health worker salaries and other benefits. This caused uncertainties for the health workforce. Municipalities as service oriented entities prioritised health worker issues and gave the highest preference to recruitment and retention of health workers in terms of budgetary allocations. In the two municipalities studied in district one and two the key informants mentioned that the outbreak of cholera in 2008 was a litmus test for health workers. The cholera outbreak was dealt with efficiently because of the robust health workforce which was highly motivated.” (KII 014 Health manager district 2)

There are also concerns about the continuing decline in

nursing standards whose origins has been linked to the crisis.

“Nurses should be trained the way they were trained in pre independence era and the early years of independence ... The hospitals are so dirty and they don’t even care. In the past we even had some SCNs who were better than doctors. I know of an SCN who knew some treatment for some diseases better than some doctors. Nurses were trained until they were “ripe.” (KII 002 Health Manager district 1).

This decline in nursing standards and unavailability of health workers has been linked to the deterioration of basic health indicators.

“Before 2009 nursing was a decent profession one could feel the zeal to advance in nursing and almost everyone was in love with his/her job but things changed because of the crisis and after 2009 it was a different profession. Nursing was faced with many challenges and simple problems began, immunisation went down because of lack of resources. Many people left their jobs going for greener pastures and there was acute shortage of material and human resources. Nursing as a profession was also affected by the issue of indiscipline among staff members and patient care was greatly compromised leading to avoidable deaths especially of children.” (KII 005 Health manager district 1)

During the crisis the minimum establishment was generally ignored as health facilities continued to operate even without key HRH. This was very common in rural areas and the remote areas were the most affected

“...there were health facilities in rural areas that operated with only a nurse aide at the height of the crisis. This contrasted with the policy on health worker establishments for rural health centres and clinic which requires that there be three nurses, one of whom should be an RGN...between the years 2005 and 2009, clinics in rural areas functioned with an establishment of health workers that did not meet the set standards of one RGN and PCN or SCN.” (KII 021 Health manager district 3)

Discussion

The study aimed to understand health worker incentives in post-crisis settings and contributes to the body of knowledge on HRH development and retention in resource poor and crisis-prone settings. This study collected perceptions and interpretations of key actors in the health system across sectors. Salient issues related to policy formulation, implementation environments and the effects of policies on HRH retention and distribution across the different sectors were interrogated. The discussion references findings from document and literature review (Chirwa et al 2014) and in-depth interview reports (Chirwa et al 2015a). The major limitation of the study is that for some sectors such as the private for profit and mission providers the participation was low. The study was done during the tenure of the unity government and all data is up to the year 2012.

The evolution of policy in the health sector has been contradictory from the early pre-crisis initiatives to unify the different providers of health services to the post-crisis period. This is characterised by the diversity of sectors providing health care to the wider public, despite the existence of the HSB which is legally tasked to manage HRH in all sectors of the health service. The incomplete task of unifying government, mission, RDC and municipal providers, which commenced towards the end of the first decade of independence is the root cause of HRH policy contradictions. The current inequities in incentives between the municipalities and the government, mission and RDC providers, emanate from the incomplete unification process. The HSB, mandated to harmonise HRH management, has been unable to make any headway due to a combination of factors. Reduced capacity by government to fund HRH remuneration has curtailed attempts to bridge the gap between salaries of government, mission and RDC and municipality health workers. The status of the municipal providers which in some respects are said to be a part of the public sector, but because of the provisions of the Local Government Act and Urban Councils Act, municipalities, have some autonomy to develop policies that provide terms and conditions that are totally different from those in government, mission and RDC sectors (Wheeler, 2010). Chimbari (2008) observes that the municipality have integrated salary grades for health workers and other categories of workers, which enables the municipalities to directly decide the remuneration of health workers without the HSB raising questions.

The public sector, which is the largest provider, has adopted measures to retain health workers over the years. The measures adopted were largely unsuccessful because of a variety of reasons. The job evaluation exercise and the subsequent performance appraisal system to link remuneration to performance were not effective primarily because of weak fiscal capacity. The performance appraisal system was further affected by a

lack of capacity from managers who were responsible for implementation (Mutizwa-Mangiza, 1998, HSB, 2010). This is why the RBM system was introduced, with a view to improve implementation. The RBM, like its predecessor, will succeed if funds are available to provide salary advances and develop capacity of health workers found to be performing poorly.

The municipality sector invariably provides better terms and conditions with revenue from the government grants, and funds generated from service charges on rate payers (Chimbari, 2008; Mbengwa 2008, Mlobane, 2010, Wheeler, 2010, Chirwa et al, 2015a p 30, Chirwa et al 2013). The findings from KIIs indicate that the 1996 performance appraisal system introduced in government, mission and RDCs was not implemented in the municipality. The RBM is also not mentioned by health managers in the municipality sector. Another key finding is that the municipalities have the advantage of seeking the approval from the minister of local government to formulate policies that attract and retain health workers. The HSB on the other hand has to go through the PSC and the PSC will consider the implications of improving salaries for health workers on the wider civil service. In many cases any initiative that was meant to address government health worker terms and conditions often fails because once the wider civil service is brought into the fray, then the issue of affordability becomes paramount and ultimately such initiatives will be stalled.

This shows that HRH conditions of service, for government, mission and RDC health workers are not the same despite the implication that municipalities are part of the public sector and that the HSB is in charge of the HRH issues in the entire health service (HSA, 2004, HSB & MoHCW, 2010, Wheeler, 2010, Chirwa et al 2014.).

During the crisis municipality providers responded to health worker needs in a robust manner and that momentum was maintained in the post crisis period. Innovative ways of handling the crisis induced demotivators like paying the health work force in cash and in foreign currency worked immensely during the crisis in retaining health workers. The special retention allowance that was introduced during the crisis such as the personal to holder allowance has been maintained for those health workers who persevered providing services during the crisis. It is not surprising that the course of internal migration is from RDC, Government and mission sector to the municipality as posited by Wheeler: ***“Harare City Council recruited 200 nurses in January 2010, and Mutare City Council was said to have recruited 12-15 nurses in late 2009 or early 2010. Although precise evidence is hard to come by, it is believed that most of these nurses were recruited from public sector institutions.”*** (Wheeler, 2010).

In the government, mission and RDC sectors, no such initiatives to respond to the immediate crisis meant

health worker needs were effective neither were they implemented on a wider scale. The general perception by health workers about the duty free importation of used cars, introduced during the crisis was implemented in a manner that was inequitable. During the crisis weak capacity to fund the initiative made it difficult to implement the initiative on a large scale. Other initiatives like the introduction of new allowances, and increases in existing allowances effected at the height of the crisis were abandoned after a few months because of unavailability of funds to support these allowances but also to deal with the dissension by other civil servants. (Chirwa et al. 2014, Chirwa et al. 2015a, Mutizwa-Mangiza 1998).

The introduction of multiple currencies as official tender and the harmonised retention allowance in the post crisis era was credited with improving recruitment in government and RDC facilities, affected by severe migration of health workers during the crisis. The mission sector did not experience high migration because of support from local and international philanthropic organisations materially which also benefitted health workers. (Chirwa et al, 2015a). In the post crisis period, recruitment improved as appointment and promotion procedures were decentralised making it faster to appoint HRH to fill vacant and promotion posts. Vacant posts were being filled expeditiously and this reduced workloads particularly for health workers in remote areas in health facilities. However because of the weak fiscal capacity of the state as it emerged from the crisis further employment of health workers was frozen in 2010 in an attempt to curb public spending. This also meant that suspension of payment of other incentives like on call, locum rural allowance and the duty free importation of cars. (HSB, 2011).

The harmonised retention allowance rewarded certain cadres and not others creating problems in service delivery. HRH in grade C4 who included the nurse aides, cooks, cleaners, ambulance drivers and rehabilitation assistants were excluded from the harmonised retention allowance and were difficult to manage. The excluded workers view the retention allowance as a mechanism to reward specific health workers never mind the fact that quality care and patient outcomes, are the sum of various inputs by a chain of health workers across various levels. Similarly in the municipality cadres not receiving the personal to holder allowances were also not happy. However the municipalities acknowledge that the disaffection of excluded cadres is not a threat to service delivery as remuneration is good.

The public sector harmonised retention scheme had a clause which stated that the allowances would be reduced annually culminating in the total removal of the retention allowance by 2013 when government would eventually takeover and incorporate the top-ups into official salaries. (HSB retention policy, 2010, HSB Annual

Report 2011:37). The government failed to meet this commitment. Incidentally, salary top-ups continued to be paid to health workers after the end of the life cycle of the harmonised retention allowance through the HTF. However health workers and some managers in the public sector are not aware that the top-ups are being funded through HTF. This is an important policy position that should have been communicated to health workers unequivocally to avoid the current confusion regarding the HTF. Lower level managers at provincial and district levels are not well informed on the modalities of the HTF. Similar sentiments on RBF were raised and this creates confusion and challenges for the managers who have to explain why these incentives are benefiting one facility and its staff but not others (Sithole, 2013). Health workers in government, mission and RDC sectors have negative perceptions on the harmonised retention allowance because the allowance does not enhance their pensions as it is not part of the official salary. The mission sector health workers are similarly aggrieved, and are additionally disaffected because the administration of their pensions is different from the government sector and thus they feel prejudiced by this arrangement. Several studies have indicated that end of service payments are effective for retention of health workers and in the indepth interviews and survey study, senior health workers cited the need to serve the remaining years before retirement in the same sector to protect their pension as the reason they remained in the current job (Chirwa et al 2015a,; 2015b).

In the municipality the retention allowance introduced during the crisis and maintained post- crisis rewards workers for staying with the municipality during the crisis. The allowance retains experienced and long serving health workers but disadvantages those currently joining the health department. Differentiation of health workers who may have, or not have similar qualifications and or experience and who perform similar tasks on the basis that they have or have not proven their loyalty to the municipality affects quality of care and patient outcomes. The retention allowance is designed and managed in such a way as to provide a weak link between performance and rewards. This has to be understood in the context of the crisis and the pressures that provider organisations had to contend with to achieve organisational objectives (Asquer, 2011, Lin, 2011).

In the private for profit sector institution the study failed to establish whether there were any retention systems in place. Failure to gain access to private providers sampled leaves us with very little data for useful analyses of how incentives and retention systems are mediated in this sector. Gupta and Dal POZ (2009) and the NIHFA (2012) contend the difficulty of accessing this sector for research. However, the fact that the private hospital visited during the study relied on public sector doctors, midwives and nurses who come for locum work indicates that the benefits for doing locum work were better at

the private hospital than in the public sector facilities. The private for profit sector benefit structure is closely guarded but because services are profit oriented, the health workers enjoy. In the indepth interviews conducted a key finding that emerged was that the payment for locum work in the public sector institutions took long to be effected and hence this could be a reason why health workers prefer doing locum work in the private institutions (Chirwa et al 2015a).

One of the key finding of the study is that HRH policies in the public sector were instigated by evidence from reviews and also international protocols. The HSB is an example of policy change that emerged from the review of the health sector. The contention by key informants is that evidence has not been used prudently in achieving optimal HRH policies. The argument being the HSB is not exactly what is recommended by the review commission but a watered down form of what had been suggested in the commission recommendation (Sikhosana, 2005). It is argued that the current challenges to effect the provisions of the health service act by the HSB is related to the failure follow the recommendations of the review commission in their entirety. It is also suggested that the delay in implementing the recommendations has also contributed to ineffective policies.

Development partners and the funds that they bring in to support HRH policies are key drivers of change. The retention allowances and HTF are reliant on the development partners' capacity to pool funds to support policies. The government through the MoHCC is also a key driver of change as policy change and formulation is delicate balancing of contending interests to achieve a desired end. The crisis was a result of a complex matrix of economic, political and relational forces. One major driver of change in the Zimbabwean context was the stabilisation of the political situation which led to a thawing of relations between the political contenders culminating in the government of national unity. This enabled reengagement with development partners which had but totally collapsed due to political polarity. This became a springboard for the formulation of policies that revitalised the health sector in the post crisis period (GoZ 2009, HSB, 2011, Witter et al, 2011)

The health sector has not fully recovered to the level it was at before the crisis because of a variety of factors, among these the persistent socio-economic crisis epitomised by constrained fiscal capacity by the government, a highly dissatisfied health work force, erosion of the public good ethos and a complex disease burden caused by HIV/AIDS, malaria, and a cholera outbreak in 2008/2009 which increased workloads. Underpinning the slow recovery is recurrent ineffective implementation of evidence based HRH policies and lack of impact assessments of time bound policies in strategic plans at the end of their implementation cycles. The challenge of implementation is also a

result of a very weak domestic financial capacity coupled with poor human capital to superintend the implementation of policies. The HSB 2011 contends that the implementation of the RBM will have to develop the capacity of managers to manage the new performance management system. This indicates depleted management capacity in the health sector impacting on the capacity to implement policies.

Conclusion

The socioeconomic crisis in Zimbabwe affected all dimensions of HRH planning and management in all provider organisations. Despite early warnings in the formative years of the HRH crisis from the commission of enquiry in 1999, lethargy to act on recommendations gave impetus to rapid deterioration of health worker availability and distribution for the public, mission and rural district council providers. The peak years of the crisis were characterised by formulation and implementation of policies, including the creation of a health service to be administered by a health service board, a recommendation made by the presidential review commission in 1999, but implemented five years later. The health service board could not resolve the crisis as funding to implement policies to retain HRH in the public sector was not forthcoming from government. Good retention policies were implemented for short periods of time and reversed and this fuelled accelerated health worker flight in the public sector.

The quest of the HSB to usher in a new ethos, where the health service would be treated differently from the wider civil service with a different salary structure and different appointment mechanisms was thwarted, because the civil service was supposed to be unified, with harmonised salaries and conditions of service. This mostly affected the public sector, mission sector and rural district councils because these sectors are in a way part of the HSB administered health service by virtue of the government grant that they receive. The municipalities on the other hand came up with policies that were quite effective in making them attractive to HRH and this tended to maintain staffing levels during the crisis and in the post crisis period.

Our analysis suggests that good remuneration and allowances impact positively on retention of health workers. The introduction of the retention allowance in the post-crisis period had a huge impact on health worker motivation. The retention allowance saw absenteeism decreasing and a reduction in trading by HRH at health facilities.

The mission sector presents challenges in that the issue of pensions is administered by a ZACH-appointed insurance company, yet salaries are administered by the Salary Services Bureau (SSB) In PSC. This raises

questions as to meaning of the general regulations on appointment on pensionable conditions. There is an aspect of discrimination in terms of the benefits attached to the two categories of workers the public sector health workers working in government owned health facilities and the mission sector which may be in this regard be defined as de facto public.

In the municipality sector the retention allowances have effectively retained older health workers. Although new health workers are disgruntled for not getting the personal to holder retention allowance because they were recruited after the crisis, they are not thinking of leaving the municipality. The municipalities continue to entice health workers from the public, mission and rural council sectors and they have achieved their organisational objective of retaining health workers. This implies that incentives or retention schemes should be designed with reference to health delivery contexts and with adequate resources to achieve desired outcomes.

Recommendations

- Fragmented human resources planning and management is causing disparities in remuneration levels. The HSB should exercise its mandate to manage HRH in all sectors to harmonise remuneration and reduce internal health worker migration.
- The crisis provided opportunities for the formulation of dynamic policies to respond to the challenges being faced by health workers, including the introduction of targeted incentives. Integration and regularisation of such incentives into the remuneration package of health workers in the long term should be pursued. The retention and incorporation of allowances into salaries will enhance pensions, which most health workers perceive to be very important, and thus retain the most experienced staff.
- Health workers should be adequately informed about incentive programmes, especially with regards to the rationale of selecting employees, to avoid some cadres of staff hearing about such policies through the grapevine.
- Implementation of HRH policies is a complex process that requires the cooperation of several government departments which often have different interests. There is need to develop a mechanism that promotes sustained engagement among the key government departments that have a role in health administration to ensure coherent remuneration policies across key public service sectors.
- The use of evidence in developing HRH policies needs to be strengthened, particularly with respect to the timeliness of translating evidence into practice as issues change over time.
- There is the need for evaluation of HRH policies by health workers themselves to provide experiential insights on the effects of policies.
- Incentive packages to minimise rural to urban migration are general, as most of them apply to all health workers, except the rural area allowance. It is important to come up with uniquely rural allowances that focus on push factors. Educational allowances to support the education of offspring and low interest loans to help improve livelihoods are important incentives that need special attention.
- There is the need to revisit the recommendation of the review commission with respect to the role of the HSB, so that its current limitations are improved.

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Annexes

Annex Key Informant Interview Guide Understanding health worker incentives in post crisis settings: Zimbabwe

Key Informant Interview with health facility managers: Topic Guide

A. Introduce the purpose of the study – its aims and scope

- Assure participant of confidentiality and how it will be maintained
- Ask for their consent to participate

B. Note details of participant.

1. Interviewee ID	6. Gender	Male	Female
2. Date of Interview	7. Age		
3. Name of RHs or HCs	8. No. of children		
4. Province	9. No. of household members		
5. Title interviewee	10. Education		

OPEN-ENDED QUESTIONS TO PROVOKE DISCUSSION:

1. Evolution of policy since 1997 Context and challenges

1.1 Looking back to 2009, after the crisis, what was the situation of health workers in Zimbabwe?

1.2 What were the main challenges for government policy in relation to the workforce?

1.2.1 Particularly focus on challenges relating to:

- a. Ability to recruit enough staff
- b. Ability to post enough staff to rural areas
- c. Ability to keep them in those areas
- d. Ability to manage them and motivate them to work effectively there

1.2.2 Which staff/cadre were most challenging to manage?

- a. How did the challenges vary across the period 2009 to present day?

1.3 Tell me about the most important context changes over the period which affected health workers

Probe:

- a. Economic changes
- b. Security changes
- c. Political changes
- d. Organisational changes
- e. International context
- f. Other

2. Policy responses

2.1 How did the government react to these challenges?

2.2 Can you explain to us how the public health sector policies have changed since 2009?

2.3 What were the objectives of the new policies?

(Focus on period of which the KI has direct experience)

Probe for changes relating to:

- a. Recruitment policies
- b. Management of staff
- c. Workload and working hours
- d. Remuneration (of all kinds, including rules about private practice, for example)
- e. Working conditions of staff and other non-financial benefits
- f. Systems of promotion and career progression
- g. Training opportunities
- h. Job security etc.

2.4 Did the policies build on what went before or not? How do the different initiatives relate to one another?

3. Drivers of changes

3.1 What were the main factors which influenced the changes in policy? (Discuss for each main policy change described)

3.2 Which factors do you think are most influential in policy change? Please explain how and why

- a. Specific people?
- b. Specific organisations?
- c. Funding?
- d. Political factors?
- e. Evidence?
- f. Other factors?
- g. Have these changed over the period? If so, describe how, and why?

3.3 Who were the main actors involved in the process of developing policies on HRH?

3.4 Describe how the main players are positioned

- a. How did and do the actors (government, experts, donors, researchers etc.) relate to one another?
- b. What is their focus of work and interest?
- c. How much influence do they have?
- d. How has this been used?
- e. Describe how this has changed or not over the post-crisis period

4. Implementation challenges

4.1 Taking each of the major reform initiatives in turn, can you describe to me how they were implemented?

- a. What were the mechanisms?
- b. Over what areas of the country?
- c. Focussed on which health workers?
- d. Implemented by whom?

4.2 What were the implementation challenges? Were they overcome? How?

4.3 What were the strengths in relation to implementation? Describe how they were achieved?

4.4 Overall, how effective was the implementation?

5. Financial impact & sustainability

- a. How costly was the policy to implement?
- b. Who funded it?
- c. How sustainable do you think it is?
- d. Is it still ongoing?
- e. If not, why not?

6. Effects of the policy change(s)

For each major policy change/intervention described by the KI, ask:

- a. Was it ever evaluated? How and by whom? What were the results?
- b. What was its overall impact, in your view?
- c. How did effects differ across regions? Across cadres? Across employers? Across ethnic groups? Across genders?
- d. How do others view the experience? What lessons have they drawn from it?
- e. Did it have any unintended effects (positive or negative)?

And more specifically:

6.1 Health worker recruitment

- a. What was the effect of the policy/intervention/programme on the number of health workers taking up posts in public service?
- b. Did it succeed in boosting numbers (if that was its aim)?
- c. If so, how?
- d. If not, why not?

6.2 Health worker retention

- a. What was the effect of the policy/intervention/programme on the number of health workers staying in public service?
- b. Did it succeed in reducing attrition (people leaving the public services) (if that was its aim)?
- c. If so, how?
- d. If not, why not?

6.3 Distribution

- a. What was the effect of the policy/intervention/programme on the distribution of health workers across the country?
- b. Did it succeed in attracting people to work in areas which are underserved (if that was its aim)?
- c. If so, how?
- d. If not, why not?

6.4 Performance

6.4.1 What was the effect of the policy/intervention/programme on the way that health workers work?

- a. Did it affect the way that they provide care to patients? If so, how?
- b. How did it affect their remuneration?
- c. Did it affect their motivation? If so, how?
- d. How about their working practices – how have they changed as a result of the policy?

6.5 Improved access to services

- a. Has the policy enabled people, especially in poorer areas, to access services at reasonable cost and quality (or had the opposite effect)?
- b. Explain your answer

6.6 Systems effects

6.6.1 Has the policy affected the wider health system? How?

6.6.2 Any positive or negative effects (whether intended or not)? Please describe them

7. Your recommendations

- a. Based on these experiences, what do you think should be done to improve the situation and work of health workers in Zimbabwe?
- b. Which strategies should be adopted in the future to address the current challenges for health workers in Zimbabwe?



Research for stronger health systems post conflict

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