Medical Leave: The Exodus of Health Professionals from Zimbabwe

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EXECUTIVE SUMMARY

Zimbabwe is faced with a growing problem of the emigration of its skilled labour. Health professionals in particular are migrating in search of greener pastures outside the country's borders. This has negatively affected the quality of health care offered in most of the country's health institutions. This policy paper draws on research work that was conducted in selected health institutions in July 2002. The study aimed to establish the magnitude of migration of health professionals, its causes and to document the associated impacts on service delivery.

The study is based on a multi-faceted methodology including a representative survey of health professionals in Zimbabwe, focus groups and key informant interviews. Attempts to interview professionals outside the country were less successful.

Zimbabwe has been experiencing a significant brain drain of doctors and nurses with two dimensions. First, within the country, health professionals have been moving from the public to the private sector. Symptomatic of the growing staffing crisis in Zimbabwe's health sector is the fact that the public health system only had 28.7% of the required number of doctors in the late 1990s. Dentists, pharmacists and even nurses were also in short supply. Of the 1,634 doctors registered in the country in 1997, only 551 (33.7%) were employed in the public sector. As many as 67% of public sector nurses are considering moving to the private sector. Second, the main subject of this paper, there has been an accelerating movement of professionals out of the country primarily to the United Kingdom, South Africa and Botswana. Some professionals use the private sector as a stepping stone between the public sector and leaving the country.

The exact numbers and whereabouts of Zimbabwean health professionals working overseas is unknown but the Health Minister noted in 2000 that Zimbabwe was losing an average of 20% of its health care professionals every year to emigration and that each of the country's five main hospitals was losing 24 senior nurses and three doctors every month. He also claimed that 100 doctors and 18,000 nurses had left since 1998. In 2002, in the United Kingdom alone, 2,346 work permits were issued to nurses from Zimbabwe. Zimbabwe was the UK's fourth largest supplier of overseas nurses, after the Philippines, India and South Africa. Also unknown is the nature of the linkages Zimbabwean professionals retain with home although remittance flows are thought to be extremely significant in propping up the Zimbabwean economy.

What this study shows is that the outflow of health professionals is unlikely to slow if the push factors do not change. The survey of health

professionals showed widespread discontent with working conditions, workloads and salaries, as well as broader economic and political conditions in the country. Amongst the key findings were the following:

- The vast majority of Zimbabwean health professionals (68.0%) are considering leaving the country in the near future. In the case of nurses, the figure is as high as 71%.
- The most likely destination (MLD) is the United Kingdom (29.0%). However, a sizable number prefer destinations within Africa (mostly South Africa followed by Botswana). Other fairly popular intended destinations include Australia, the US, New Zealand and Canada.
- More than half of the respondents (54.7%) cited economic factors as a reason for leaving. These included better remuneration in the intended country of destination (55%) or the desire to make money to remit home (54%). Illustratively, Zimbabwean nurses earned an average of Z$18,000 a month in 2001. This compares extremely unfavourably with the Z$82,600 to Z$110,625 a month they could earn in Australia and Z$154,000 a month in the US.
- There is widespread dissatisfaction with the benefits offered in the public sector. The respondents argued that the sector does not offer competitive salaries (87%). Some 68% said they found it difficult to live on their existing salary and 79% said that it was necessary to do two or more jobs to make ends meet.
- Professional reasons influencing potential emigration decisions include the lack of resources and facilities (42.9%), heavy workloads (39.4%) and insufficient opportunities for promotion and self-improvement (32.2%).

The research results showed that most of the country's public health institutions are grossly understaffed and the skeletal staff that remains are reeling under heavy workloads.

Nearly 80% of the respondents indicated that they lack basic equipment at their health institutions, such as injections and thermometers. The absence of such basic equipment makes it difficult for health professionals to conduct their duties efficiently and this consequently affects their morale. Nearly 40% of the respondents indicated that their health institutions do not take adequate measures to protect them from contracting the AIDS virus. Over 50% of doctors and nurses are constantly worried that they will get infected at work.

The shortage of suitably qualified health professionals in the country's public health institutions has increased the workload of those who remain. For instance, half of the respondents attend to more than 20 patients per shift while only 9.5% attend to less than five per shift. As

many as 78% of the health professionals expressed dissatisfaction over patient load which they regard as extremely high and increasing. They blamed emigration for the increase. In this case, the migration of health staff is seen as both a cause of ongoing migration (by increasing workload of remaining health professionals) and its effect (due to the reduction of available health professionals).

The study showed that both urban and rural health institutions have been affected by migration, with those located in rural areas being the most affected. The situation is better in urban areas which have alternative sources of medical healthcare in the form of private health institutions. Besides offering better services to patients, albeit at a higher fee, the private health sector also provides an escape route for the disgruntled public health sector professionals who find the salaries offered by the public sector unattractive. The poor have been negatively affected since they cannot afford the fees charged at private clinics.

The study shows that existing policy responses are not having a significant impact on the retention and return of health professionals. A speedy resolution to the current economic and political crisis is a prerequisite for curbing the ongoing migration of health professionals from Zimbabwe. Policies aimed at retaining existing and re-attracting emigrant staff are likely to have much greater success in a transformed economic and political environment.

INTRODUCTION

> *"What we are witnessing in Zimbabwe in the health sector is a brain haemorrhage"* (Zimbabwean doctor, cited in Daily News, 20 October 2000).

The migration of skilled professionals from the developing countries of the South (the so-called "brain drain) has recently been the subject of much policy discussion globally and regionally.[1] Knowledge of the magnitude and impact of the phenomenon, particularly from and within Africa, is limited because of a lack of reliable data. Where statistics are available, they tend to be of poor quality. Hence, it is difficult to determine who the migrants are and why they are leaving in such numbers. Policy responses therefore occur in something of an information vacuum.

The movement of skilled professionals to industrialised countries has decimated Africa's human capital base.[2] In the mid-1990s, Africa was losing about 23,000 professionals annually in search of better working conditions in the developed world.[3] The figures show a steady increase in the number of skilled professionals migrating from Africa to developed countries. Equally disturbing is the fact that the continent spends nearly $4 billion annually to replace emigrating professionals with expatriates from the West, a figure which represents nearly 35% of Africa's total Overseas Development Assistance (ODA).[4] Expatriates are more expensive to employ than locally-trained professionals and the fact that they are usually only prepared to work in the host country for a limited period of time makes sustainable economic development even more difficult to achieve.

More recently, a new trend had emerged in the "brain drain." An increasing number of skilled African professionals have been moving to destinations within Africa. The extent of this new form of South-South migration is uncertain. Three reasons have been identified for the shift to South-South migration: (a) the economic opportunities for migration to developed countries declined; (b) there has been increased economic differentiation among African countries; and (c) educational output expanded faster than the economies in many African countries, leading to disparities between the supply and demand for skilled workers and to the out-migration of those unable to find work at home.[5] Certainly, the second of these two factors still applies with inequality continuing to grow within and between African countries. However, globalization and the demand for developing country professionals have grown again over the last decade, leading to aggressive recruiting campaigns by many countries in the North.[6] In addition, most countries are now character-

ized more by a shortfall than a surplus of skilled professionals.

Sectorally, health has been particularly badly affected by the new African brain drain with unprecedented opportunities for mobility globally and a marked deterioration in working conditions and prospects at home. Many African countries are losing skilled health professionals at an accelerating rate.[7] Poor working conditions, insufficient remuneration, delayed promotions, lack of recognition, and inability to afford the basic necessities of life are all cited as reasons for dissatisfaction. In addition, the HIV/AIDS pandemic has increased the workload on health workers and exposed them to additional risks at a time when the number of available health workers has declined. Consequently, health professionals often migrate in search of more profitable situations, both financially and professionally.

In Zimbabwe, a general brain drain of skilled personnel has been gathering momentum over the last decade. In particular, the political and economic situation in the country is generally seen as a major factor precipitating out-migration.[8] Detailed and reliable sectoral knowledge of the brain drain is less readily available. This study set out to remedy this situation by systematically examining the extent and impact of the brain drain on Zimbabwe's health sector.

SURVEYING THE HEALTH SYSTEM

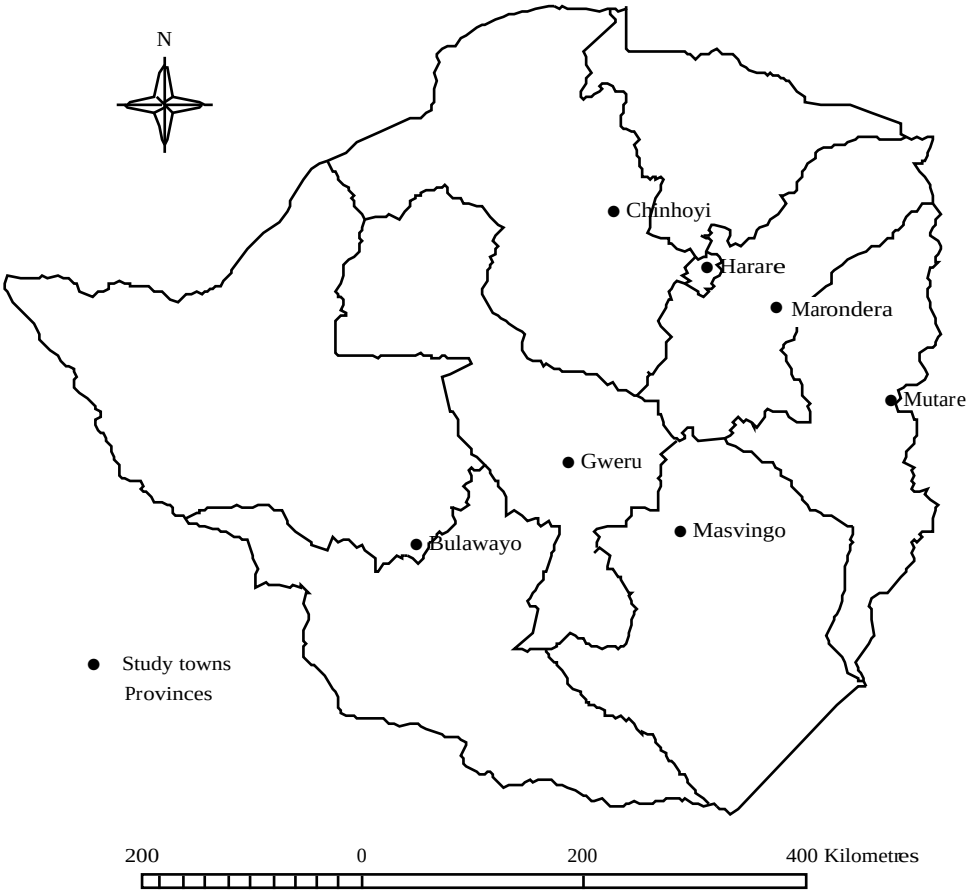
Five inter-linked research instruments were developed in order to better understand the dimensions, causes, impacts and future course of the medical brain drain from Zimbabwe. The first (A1 questionnaire) was administered to hospital authorities as well as to the Ministry of Health and Child Welfare (MoHCW) and sought to establish staffing patterns at Zimbabwean health institutions over the past decade. In addition, it collected data on the workload of the various health worker categories at each health institution. The A2 questionnaire was used to interview informants in key positions in the health delivery system. The A3 questionnaire was administered to individual health workers from selected health institutions. The A4 questionnaire was a guide for focus group discussions (FGD) with key community stakeholders. The A5 questionnaire was administered to emigrant health professionals. The methodologies employed in selecting respondents for each research instrument are outlined below.

THE HEALTH INSTITUTION SURVEY (A1)

Random sampling was employed in selecting health care facilities. Zimbabwe has ten provinces (eight proper and two cities) and seven of

these were randomly selected for sampling. In each of the selected provinces, the main provincial town or city was selected as well as one district health institution and one health centre. One questionnaire was distributed to each health institution for completion by the hospital superintendent. The provincial hospitals selected for the study are shown in Figure 1.

Figure 1: Location of main study centres



The selection of health centres was guided by the authorities interviewed at district centres. One health centre was targeted for each district hospital. Two schools of Nursing and Midwifery were also selected, located at Harare and Mpilo Central Hospitals.

PROFESSIONAL INFORMANTS (A2)

Interviews were held with professional informants in key positions in the health system, other sectors, and relevant partners. They included

personnel from the Ministry of Health and Child Welfare (MoHCW); members of professional councils/associations; representatives of partner organisations and representatives of the private health sector.

INDIVIDUAL HEALTH WORKERS (A3)

The A3 questionnaire was administered in the health institutions which had been randomly selected for the A1 questionnaire. It was not possible to obtain data on the number of health professionals employed in each of the selected institutions from the MoHCW. This presented a problem in determining the target number of respondents for each of the institutions. The study thus relied on informal figures presented by individuals with expert knowledge of staffing patterns in the country's hospitals. The sample sizes calculated for the respective health institutions are shown in Table 1. In total, 312 individuals were identified for interviews, including 215 nurses and 59 doctors. Some 231 completed questionnaires were returned (return rate of 75%). Of these, 66.2% were female and 33.8% male (Table 2). Furthermore, 64.1% of the respondents were married, 25.1% single, 5.2% divorced and 5.6% widowed. The respondents were mostly Zimbabwean (98.3%).

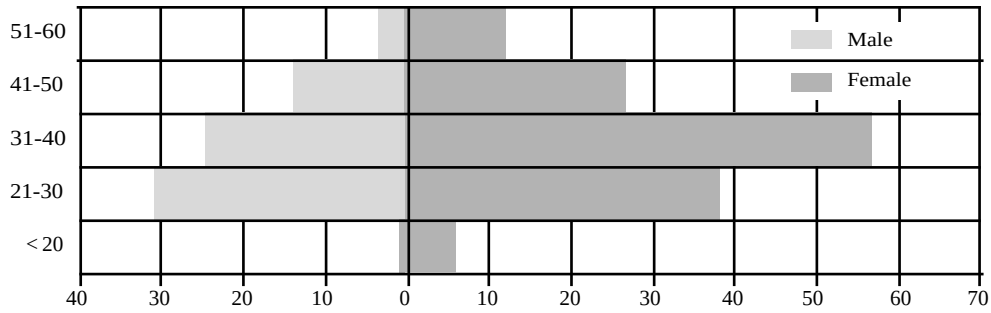
Table 1: Breakdown of Health Professional Respondents

Hospital	Doctors	Pharmacists	Nurses	Dentists	Total
Parirenyatwa	11	5	62	2	80
Harare Central	5	2	32	1	40
Mpilo	5	2	32	1	40
Mutare	3	1	7	1	12
Chinhoyi	5	2	7	1	15
Kadoma	3	1	7	1	12
Kariba	2	1	6	1	10
Gweru	5	2	7	1	15
Marondera	2	1	6	1	10
Masvingo	5	2	7	1	15
Nyanga	2	1	6	1	10
Bonda	2	1	6	1	10
UZ Medical School	9	2	2	2	15
Nursing and Midwifery schools	-	-	4	-	4
Health Centres	-	-	24	-	24
Total	59	23	215	15	312

Table 2: Profile of Respondents		
	No.	%
Gender of respondents		
Male	78	33.8
Female	153	66.2
Marital status		
Married	148	64.1
Divorced	12	5.2
Single	58	25.1
Widowed	13	5.6
Nationality		
Zimbabwean	227	98.3
Another African country	1	0.4
British	1	0.4
Australian	1	0.4
Any other country	1	0.4
N = 231		

Most of the respondents (64.5%) were in their most productive working years (aged between 21 and 40 years) (Figure 2). The structure of the age-sex pyramid for the health professionals interviewed indicates that Zimbabwe's health sector is heavily feminised.

Figure 2: Age profile of respondents



Nurses were the largest group of health professionals interviewed, comprising almost 60% of respondents (Table 3). A smaller number of doctors (13%) were interviewed, with a smattering of pharmacists, midwives, dentists and tutors/lecturers at nursing schools and the medical school.

Table 3: Employment Profile of Respondents		
	No.	%
Category of health team		
Nurse	137	59.3
Midwife	20	8.7
Medical doctor	30	13.0
Pharmacist	10	4.3
Tutor/lecturer	17	7.4
Dentist	5	2.2
Any other category	12	5.2
Sector of employment		
Public sector	221	95.7
Private sector	10	4.3
Type of facility employed in		
District hospital	39	16.9
Provincial or regional hospital	117	50.6
Tertiary hospital	41	17.7
Rural health centre	9	3.9
Nursing school in a university	2	0.9
Nursing school not in a university	13	5.6
Medical school	10	4.3
N = 231		

Nearly half of the respondents were drawn from provincial hospitals, while others were from district (16.9%) and tertiary hospitals (17.7%). The rest were drawn from rural health centres (3.9%), nursing schools (6.5%) and from the medical school (4.3%). The health professionals interviewed are highly qualified. The majority hold tertiary diplomas (65.8%), with 19.9% possessing bachelors' degrees. Some 6.1% possess tertiary certificates while 1.3% possess other qualifications. Noteworthy, are the 5.2% who possess Masters' degrees while 1.7% have doctorates.

FOCUS GROUPS (A4)

The focus group discussions were held in Epworth, a suburb located just outside the administrative boundary of Harare, the capital. Three focus groups were held with the participants identified in Table 4.

Table 4: Focus Group Participants	
Group	Composition
1 (n = 12)	• Religious leaders (2) • Senior teacher/teacher in charge (1) • Traditional healer/practitioner (1) • Community representatives/clubs (2) • Home based care givers (3) • Traditional midwives (2) • Village community worker (1)
2 (n = 12)	• Adolescent users of health services (6 females, 6 males, ages 15-19 years)
3 (n = 12)	• Adult users of health services (6 women of child bearing age (30+ years); 6 men (30-50+ years))
N = 36	

EMIGRANT HEALTH PROFESSIONALS (A5)

The A5 research instrument was designed to survey doctors, nurses and pharmacists residing outside the country. However, response rates were extremely low. Only 25 completed questionnaires were returned. More research is clearly needed in this area

STAFFING THE HEALTH SECTOR

Current and completely reliable figures on the stock and extent of emigration of skilled health professionals from Zimbabwe are unavailable. In 2000, Health Minister, Timothy Stamps, was quoted in the press as saying that Zimbabwe had been losing an average of 20% of its health care professionals every year to emigration and that each of the country's five main hospitals was losing 24 senior nurses and three doctors every month. Stamps also claimed that 100 doctors and 18,000 nurses had left since 1998. Finance Minister Makoni noted that Zimbabwe had lost 41 doctors and 341 nurses in 2002 which may be something of an underestimate.[9] In 2002, in the United Kingdom alone, 2,346 work permits were issued to nurses from Zimbabwe (Table 5). Zimbabwe was the UK's fourth largest supplier of overseas nurses, after the Philippines, India and South Africa.

Table 5: Work Permits Issued to Nurses in UK, 2002	
Country	No. of Work Permits Issued
Philippines	10,424
India	3,392
South Africa	2,835
Zimbabwe	2,346
Nigeria	1,501
Ghana	528
Australia	503
Pakistan	385
Kenya	354
Mauritius	351
Other	2,983
Total	25,602
Source: Davlo, "Brain Drain and Retention of Health Professionals in Africa", p 9 (see endnote 9).	

Data obtained from the Zimbabwean Central Statistical Office (CSO) showed that the number of registered medical doctors and specialists countrywide increased slightly from 1,575 in 1995 to 1,629 in 2000 (a 3% increase) (Figure 3).[10] However, the Medical School of the University of Zimbabwe trains about 80-90 doctors every year. There was an overall increase of only 54 doctors (rather than an expected 400 plus) over the five-year period. Emigration is at least partially responsible for the discrepancy.[11]

Figure 3: Registered medical practitioners in Zimbabwe, 1995-2000

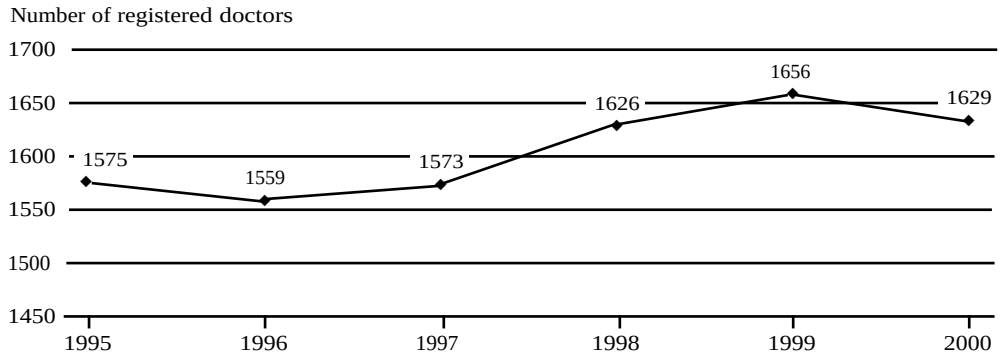
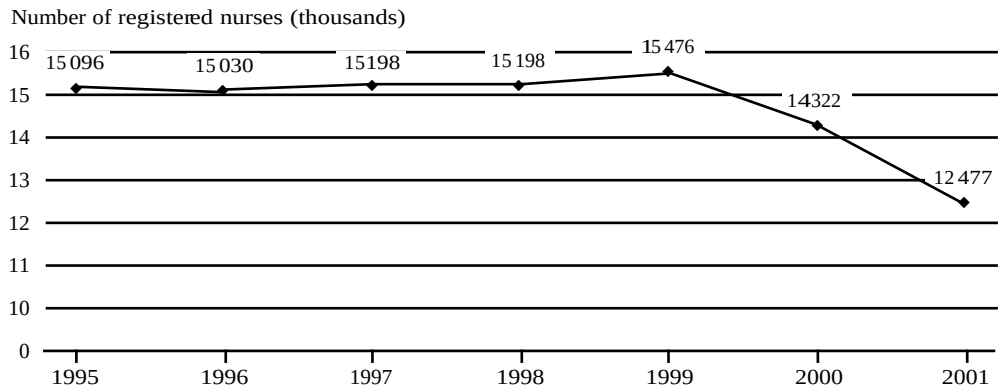


Figure 4 shows that the number of registered nursing professionals in the country was stable up to the late 1990s, after which a significant decline was experienced. There were 15,476 registered nurses in Zimbabwe in 1998, only 12,477 remained by 2001. Such a sudden decline is a cause for concern and is clearly a result of the emigration of nurses from the country.[12]

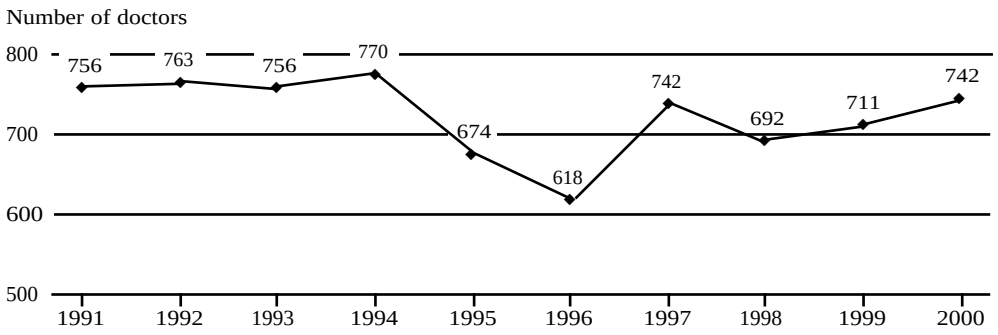
Figure 4: Registered nurses in Zimbabwe, 1995-2000



The public health sector is the principal provider of health care in most African countries and offers affordable health care to many disadvantaged people. A brain drain from the public sector (whether to the private sector or out of the country) therefore impacts disproportionately on the poor. It is therefore important to investigate staffing pattems in this sector. Data on staffing patterns in public health institutions was collected from the Ministry of Health and Child Welfare (MoHCW). The MoHCW could only provide information relating to staffing patterns for nurses and doctors. Data for dentists and pharmacists was not available. Also, data was only available to 2001. All indications are that the brain drain further accelerated in 2002-3. The number of doctors employed countrywide in public health institutions fell from 756 in 1991 to 618 in 1996 (Figure 5). The staffing figures did rise again in the late 1990s but the figure of 742 in 2000 was still lower than the figure a decade earlier.

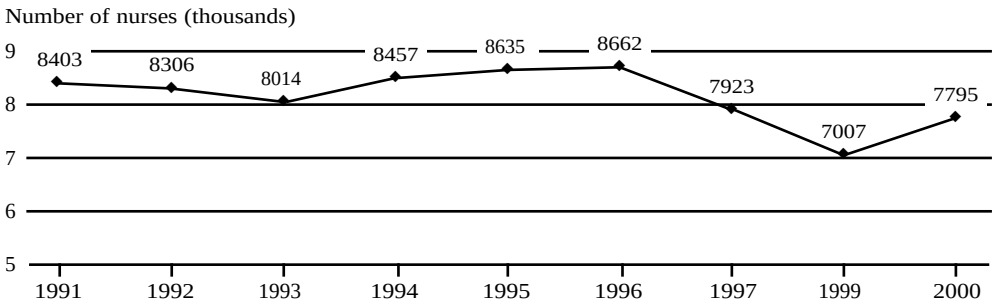
The number of nurses employed in the public health sector fell by 1,655 (19.1%) from a peak of 8,662 in 1996 to 7,007 in 1999 (Figure 6). This decline occurred during a period when the country's public training institutions produced 1,370 newly-minted nurses (Figure 7). While some of the nurses might have left the public sector through attrition (such as retirement and death) or moving to the private sector, a significant proportion of the departures may be blamed on emigration.

Figure 5: Number of doctors in the public health sector, 1991-2000



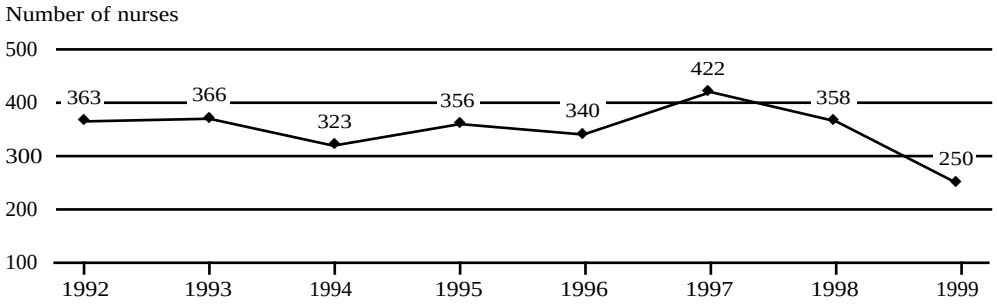
This lends credence to media reports that many Zimbabwean-trained nurses are leaving for overseas destinations such as the UK where salaries are much higher than those offered locally.

Figure 6: Number of nurses in the public health sector, 1991-2000



Note: Data not available for 1998

Figure 7: Number of nurses trained in Zimbabwe, 1992-1999



The health sector of Zimbabwe has been badly affected by the brain drain phenomenon. Owing to the good quality of education and training they receive, Zimbabwean health professionals are currently in high demand in European countries (mostly in the UK) as well as in other African countries such as South Africa and Botswana. Local salaries compare poorly with those in the developed world. In 2001, for instance, Australia-bound nurses expected to get between Z$82,600 and Z$110,625 a month, while US-bound nurses expected to earn at least Z$154,000 a month.[13] This compares extremely unfavourably with the Z$18,000 a month they were getting in Zimbabwe in the same year. The UK has been a particularly popular destination for emigrant Zimbabwean nurses. Opportunities for nursing jobs in the UK are being created due to the mass exodus of nurses into private business.[14] There has also been a reduction in the number of young people choosing nursing careers in the UK, so that retiring nurses are not being replaced.[15] Such a situation has reduced countries such as Zimbabwe to "training grounds" for health professionals.[16]

The shortage of pharmacists, in particular, has been worsened by strong recruitment drives by developed countries, notably the United Kingdom. During the past two years alone, Zimbabwe has lost between 60 and 80 pharmacists to other countries, with the United Kingdom being the main destination. For a country with just over 500 pharmacists in total and which produces an average of only 25 new pharmacists a year, the impact is considerable. In early 2002, there were press reports of nearly sixty Zimbabwean trained pharmacists on the same plane destined for the UK.[17] A similar number of pharmacists were expected to leave the country for the same destination later that year.

A comparison of the number of registered professionals in the country and those employed in public health institutions shows that the public sector is also in crisis because of its failure to retain staff, leading to an internal "brain drain" to the private sector. In 1997, for example, there were 831 private and 745 public sector doctors. Two years later, in 1999, the figures were 945 and 711, a situation which suggests that the private sector has been growing at the expense of the public sector (Figure 8).

The public sector share of nurses in Zimbabwe also fell during the mid-1990s (Figure 9). Evidence that nurses have been moving to the private sector is also provided by the number of nurses registered nationally, which rose marginally from 15,096 in 1995 to 15,476 in 1999 (an increase of 2.5%), while the number of nurses employed in public health institutions declined from 8,635 in 1995 to 7,007 in 1999 (a decline of 19%).

Figure 8: Public versus private sector share of doctors

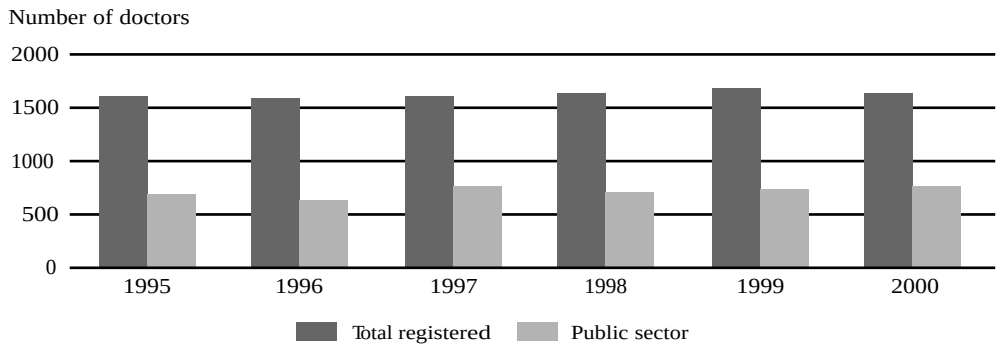
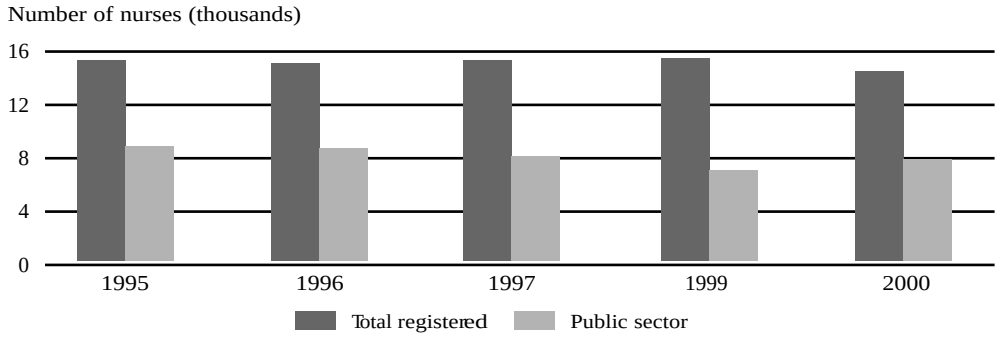


Figure 9: Public versus private sector share of nurses



Note: Data not available for 1998

Symptomatic of the growing staffing crisis in Zimbabwe's health sector is the fact that the public health system only had 28.7% of the required number of doctors in the late 1990s (Table 6). Dentists, pharmacists and even nurses were also in short supply. Of the 1,634 doctors registered in the country in 1997, only 551 (33.7%) were employed in the public sector.

Table 6: Health Professionals Employed in the Public Sector, 1997

	No. Registered in the Country	MoHCW Requirement	Approved Posts	Filled Posts	% of Requirement Filled
Doctors	1,634	1,851	676	551	28.7
Nurses	16,407	14,251	7,923	7,923	55.6
Pharmacists	524	198	59	37	18.7
Dentists	148	43	14	14	32.6

Source: MoHCW

At the public health institution level, the migration of skilled health professionals to the private sector and out of the country has led to serious staff shortages. The number of unfilled posts is increasing for certain categories of professional, such as nurses. For instance, the number of unfilled posts at Harare Central Hospital increased from 118 in 1998 to 340 in 2000. Health institutions located in urban areas are certainly better staffed with health professionals than those in disadvantaged (rural) areas (Table 7). Rural health institutions are grossly understaffed and have high vacancy rates. Similarly, provincial hospitals are better staffed than district hospitals.

Most health institutions have experienced a reduction in the number of nursing professionals employed and consequently an increase in the number of vacant posts. Harare Central Hospital, for instance, had 676 nurses employed in 1998 and only 594 were left by 2000. The dramatic increase in the number of vacant nursing posts at Harare Central Hospital in 2000 was also due to the increase in the number of established posts from 794 to 934. The number of vacant posts is generally inversely proportional to the population size of an area. Two main reasons may be advanced for the large number of vacant posts observed in large urban areas compared to smaller ones. Firstly, nurses in large urban areas (like Harare) are lured to join the private sector which offers better returns for labour. Private practices are more prevalent in urban areas. Secondly, the increased flows of information and easy access to communication networks in metropolitan areas expose the nurses to job opportunities in other countries, both regionally and overseas. This may induce a desire to migrate.

REASONS FOR LEAVING

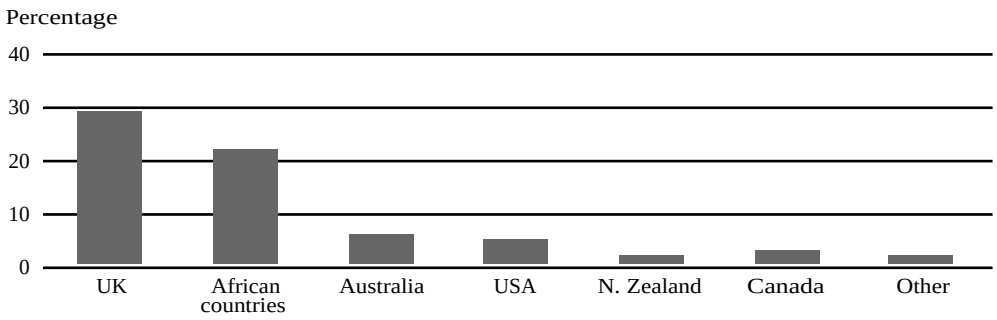
An examination of the migration intentions of in-country health professionals provides a useful indication of likely future brain drain patterns. The survey showed that the vast majority of Zimbabwean health professionals (68.0%) are considering leaving the country in the near future. In the case of nurses, the figure is as high as 71%. The most likely destination (MLD) is the United Kingdom (29.0%). However, a sizable number prefer destinations within Africa (mostly South Africa followed by Botswana). Other fairly popular intended destinations include Australia (5.6%), the US (4.8%), New Zealand (2.2%) and Canada (2.2%) (see Figure 10). Even though intentions do not automatically translate into action, the extent of dissatisfaction in the health sector is clearly massive.

Table 7: Staffing Patterns at Selected Public Health Institutions

	Variable		1995	1996	1997	1998	1999	2000
Doctors	Harare Central Hospital	Established Posts	-	-	-	108	122	122
		Number at Post	-	-	-	94	118	193
		Vacant Posts	-	-	-	14	4	+71*
	Gweru Provincial Hospital	Established Posts	8	8	8	8	8	8
		Number at Post	5	4	7	7	8	8
		Vacant Posts	3	4	1	1	0	0
	Kadoma District Hospital	Established Posts	-	6	6	7	6	7
		Number at Post	-	5	6	7	6	6
		Vacant Posts	-	1	0	0	0	1
Nurses	Harare Central Hospital	Established Posts	-	-	-	794	794	934
		Number at Post	-	-	-	676	606	594
		Vacant Posts	-	-	-	118	188	340
	Gweru Provincial Hospital	Established Posts	236	242	242	242	242	242
		Number at Post	231	230	237	238	232	235
		Vacant Posts	5	12	5	4	10	7
	Kadoma District Hospital	Established Posts	-	108	112	116	119	119
		Number at Post	-	105	90	105	113	112
		Vacant Posts	-	3	22	11	6	7
	Epworth Poly Clinic	Established Posts	-	-	-	7	7	7
		Number at Post	-	-	-	5	5	4
		Vacant Posts	-	-	-	2	2	3
Mid-wives	Harare Central Hospital	Established Posts	-	-	-	60	60	60
		Number at Post	-	-	-	60	60	55
		Vacant Posts	-	-	-	0	0	5
	Epworth Poly Clinic	Established Posts	-	-	-	12	12	12
		Number at Post	-	-	-	10	8	9
		Vacant Posts	-	-	-	2	4	3
Pharma-cists	Harare Central Hospital	Established Posts	-	-	-	8	8	10
		Number at Post	-	-	-	5	6	6
		Vacant Posts	-	-	-	3	2	4
	Gweru Provincial Hospital	Established Posts	2	2	2	2	2	2
		Number at Post	2	2	1	1	1	1
		Vacant Posts	0	0	1	1	1	1
	Kadoma District Hospital	Established Posts	-	1	1	1	1	1
		Number at Post	-	1	1	1	1	1
		Vacant Posts	-	0	0	0	0	0

* Positive sign shows that the health institution employs excess staff
Source: MoHCW

Figure 10: Most likely destinations of departing health professionals



The survey also sought to establish the causes of health professional disenchantment. The study results reveal that the reasons are varied and can be broadly grouped into economic, political, professional and social factors. More than half of the respondents (54.7%) cited economic factors as a reason for leaving (Table 8). Economic factors cited include the desire to receive better remuneration in the intended country of destination (55%) or the desire to save money quickly (54%) for later use in the home country.

Political factors cited included pessimism about the future (cited by 45%), the general mood of despondency in the country (24.2%) and the high levels of crime and violence (22.9%). Professional factors influencing potential emigration decisions included the lack of resources and facilities (42.9%), heavy workloads (39.4%) and insufficient opportunities for promotion and self-improvement (32.2%). Lastly, social factors cited included the desire to find better living conditions (47.2%) and children's safety (25.1%).

Without question, economic factors exert the greatest influence on health professionals. This is in line with the general decline in the country's economic conditions since the late 1990s. Political factors have also gained greater prominence, as the country's major political parties fought fierce battles, first in the 2000 parliamentary elections, and then in the 2002 presidential elections. The campaigns were associated with widespread violence, which was more severe in rural areas. This saw many professionals fleeing the country for their safety and that of their children. Still other health professionals are migrating because of professional factors. Most of these factors relate to the poor economic conditions prevailing in the country (eg general decline of health care services in the country).

Table 8: Reasons for Intention to Leave	
Reason	Percentage
Economic	54.7
Because I will receive better remuneration in another country	55.0
Because of a general decline in the economic situation in this country	55.0
To save money quickly in order to buy a car, pay off a home loan, or for a similar reason	54.1
Political	30.7
Because I see no future in this country	45.0
Because there is a general sense of despondency in this country	24.2
Because of the high levels of violence and crime in this country	22.9
Professional	29.6
Because of a lack of resources and facilities within the health care system of this country	45.0
Because there is a general decline in the health care services of this country	42.9
Because the workload in the health services of this country is too heavy	39.4
Because of insufficient opportunities for promotion and self-improvement	32.2
To gain experience abroad	32.0
Because of the poor management of the health services in this country	30.7
Because I need to upgrade my professional qualifications due to the unsatisfactory quality of education and training in this country	22.9
Because I can not find a suitable job in this country	11.3
Because an unacceptable work tempo is expected of me in this country	10.4
Social	23.9
In order to find better living conditions	47.2
Because the value systems in this country have declined to such an extent that I can no longer see my way clear to remain here	32.0
To ensure a safer environment for my children	25.1
In order to travel and see the world	14.7
In order to join family / friends abroad	14.3
Because of family related matters	10.0
N = 231	
Note: question is multiple response	

WORKING CONDITIONS IN THE HEALTH SECTOR

This study confirmed earlier findings that health professionals in Zimbabwe are highly dissatisfied with their current working conditions.[18] Information was sought regarding indicators of working conditions, such as working hours, client attendance, and quality of services offered at the health institutions. Most health professionals in Zimbabwe are officially supposed to be on duty for between 31 and 40 hours a week (that is, nearly 8 hours a day). However, due to staffing problems, some health professionals end up working up to 4 extra hours a day. In the study, a small number of respondents (1.3%) are sometimes on duty for more than 50 hours per week, 10 hours more than the stipulated national average.

The shortage of foreign currency in Zimbabwe has also affected service delivery in most health institutions, which rely on drugs and equipment that are mostly imported from other countries. Nearly 80% of the respondents indicated that they lack basic equipment at their health institutions, such as injections and thermometers. The absence of such basic equipment makes it difficult for health professionals to conduct their duties efficiently and this consequently affects their morale. This may also be a further motivational factor to leave.

The research also showed that as many as 67% of public sector nurses are considering moving to the private sector. The most commonly cited reasons for the intended move are the search for better remuneration and working conditions. Even those who choose to remain in the public sector may be involved in 'moonlighting' in the private health institutions in an effort to augment their salaries.

Even though the health professionals complained of heavy workloads, most of them (74.9%) were willing to handle more responsibility in their work (Table 9). However, 39% of the respondents complained that their skills and knowledge are not being fully utilized, which may increase the attractiveness of migrating to other destinations where they can fully apply their professional skills. Professional integrity still appears to be robust with very few being aware of bribery and corruption in their health care facility.

There is widespread disgruntlement about the benefits offered in the public sector. The respondents argued that the sector does not offer competitive salaries (87%). Some 68% said they found it difficult to live on their existing salary and 79% concurred that it was necessary for public health sector professionals to do two or more jobs to make ends meet (Table 10). The research established that health professionals who remain in public employment increasingly augment their salaries by other means. These include moonlighting in private facilities, attending

Table 9: Working Conditions		
	No.	%
Ability to handle more responsibility in your work		
Yes	173	74.9
No	47	20.3
No Response	11	4.8
Are your skills and knowledge fully utilized in your work		
Yes	141	61.0
No	78	33.8
No Response	12	5.2
Instances of illegal payment/bribes within the health care facility where you work		
Yes	13	5.6
No	181	78.4
Don't know	37	16.0
N = 231		

to non-medical businesses, and informally requesting payments for services. The effects of such activities on the quality of care are a subject for future research.

While doctors have been able to establish private surgeries, nurses in Zimbabwe are hampered from doing so by the current legal framework. Hence, for most nurses, migrating to the private sector remains the only viable option. However, some public sector health nurses who choose not to migrate to the private sector are engaged in part time work in the private sector to augment their salaries. One focus group participant alleged that: "Nurses in the public sector are engaging in a lot of part-time work in private clinics. By the time they come for their normal duties, they will be too tired to work. That is why we get poor service when we visit the clinic." The public sector is then largely left with individuals who are poorly motivated to perform their duties.

Most health professionals (87%) would be prepared to stay in the public sector if they were offered better salaries, but many (68%) are considering moving to the private sector. The private sector clearly offers better fringe benefits than the public sector. The respondents expressed fears over their social security in old age, with 81% indicating that they fear that they will not be adequately provided for when they retire. Very few (only 16%) could see any advantage to working in rural areas.

Table 10: Attitudes to Remuneration in the Public and Private Sectors (%)	
The public health sector does not offer competitive salaries to health workers in this country	87
If I received a better salary, I would be happy to stay in my present position	87
If you work in the public health service, it is necessary to do two (or more) jobs to make ends meet	79
The private sector offers better fringe benefits to health workers in this country than the public sector	78
I find it difficult to live on the salary I receive	68
I am considering moving to the private sector because I will receive a better salary	68
Do you agree with the following statements?	
I worry that I will not be adequately provided for when I retire	81
Working in a rural area means that I will have to live in poor housing	54
There are positive incentives for working in a rural area in my country	16
N = 231	

The movement of health professionals into the private sector or out of the country are not mutually exclusive options. As international migration has become so expensive (for instance, international airfares in Zimbabwe are now being charged in US$), the private sector provides the necessary launching pad for the eventual move abroad. Thus, professionals who move to the private sector are able to save the necessary airfares which eventually facilitates their move abroad.

In some cases, direct migration of nurses from the public sector is still occurring. This pattern is mostly being sustained by kinship ties, whereby friends and relatives who reside overseas purchase air tickets for the prospective migrant.

Another major push factor is the AIDS pandemic. Zimbabwe is one of several sub-Saharan African countries that are badly affected by the HIV/AIDS pandemic, with an estimated 25-30% of the sexually-active population affected by the virus.[19] However, the impact of HIV/AIDS on the migration of health professionals is not known. It should be noted also that health professionals have not been spared by the disease. Many are dying and not being replaced.

Nearly 40% of the respondents indicated that their health institutions do not take adequate measures to protect them from contracting the virus. The absence of adequate protection creates an unsafe environment for professionals. Not surprisingly, 58% (64% of nurses) are constantly worried that they will get infected at work. Health workers, particularly nurses and midwives, at some public health sector institutions reported a shortage of gloves which increases their risk of contracting the virus, especially when conducting deliveries. Thus, some nurses suggested that a risk allowance be introduced. The disease has

increased the workload of health professionals, with 58% indicating that they find caring for HIV/AIDS patients is stressful. In sum, the epidemic is clearly having a major impact on the levels of work stress and perceptions of personal risk. To that extent, it may also be a factor prompting people to move to the private sector or out of the country.

EFFECTS OF THE MEDICAL BRAIN DRAIN

The shortage of skilled health professionals has impacted negatively on the workloads of the staff that choose not to migrate. The MoHCW estimates the current doctor/patient ratio as one doctor to 6,000 patients, but the research established that this is not common at all levels of the healthcare system. This section assesses the effects of migration of health professionals on the quality of health care.

Data on the workload of doctors shows that those employed in district hospitals have a heavier workload than their counterparts working in provincial and central hospitals (Table 11). This is related to another finding that health institutions located in urban areas are better staffed than those in rural areas. Doctors posted to areas with lower levels of development clearly have a much heavier workload than those employed in more developed city areas. For instance, while the outpatient attendance per doctor at Gweru Provincial Hospital was 1: 8,650 in 2000, the attendance per doctor at Kadoma District Hospital was 1: 27,709.

In Zimbabwe, nurses form the backbone of the country's health delivery system and they run most health centres in disadvantaged areas. Nurses working in rural areas have over the years functioned in an increasingly expanded role, taking on the role of pharmacist, doctor, physiotherapist and so forth. This has negatively impacted on the workloads of nurses stationed in less attractive regions. According to the MoHCW estimates, the current nurse/patient ratio is one nurse to 700 patients, but the study established that nurses employed at provincial health institutions have nurse to patient ratios lower than the national average (Table 11).[20] For instance, in 2000 the nurse to patient ratio for Gweru Provincial Hospital was 1:177 (below the national average). This compares to a ratio of 1: 1,484 at Kadoma District Hospital. The situation is worse for nurses employed at the health centres where doctor visits are rare. For instance, the nurse to patient attendance ratio in 2000 at Waverly Clinic (a health centre in Kadoma) stood at 1: 7,500 and at 1: 10,500 for Epworth Poly Clinic (a health centre at the outskirts of Harare). The pattern that emerges is that nurses employed on health centres endure very heavy workloads and the situation improves

Table 11: Patient Attendance in Selected Health Institutions in Zimbabwe								
		Variable	1995	1996	1997	1998	1999	2000
Doctors	Gweru Provincial Hospital	No. of patients	143,196	126,369	166,861	162,613	166,863	69,202
		No. at post	5	4	7	7	8	8
		Attendance per doctor	28,639	31,592	23,837	23,230	20,858	8,650
	Kadoma District Hospital	No. of patients	192,707	133,509	181,185	182,755	180,087	166,255
		No. at post	7	5	6	7	6	6
		Attendance per doctor	27,530	26,702	30,198	26,108	30,015	27,709
Nurses	Gweru Provincial Hospital	No. of patients	143,196	126,369	39,428	40,503	40,819	41,629
		No. at post	231	230	237	238	232	235
		Attendance per nurse	620	549	166	170	176	177
	Kadoma District Hospital	No. of patients	192,707	133,509	181,185	182,755	180,087	166,255
		No. at post	112	105	90	105	113	112
		Attendance per nurse	1,721	1,272	2,013	1,741	1,594	1,484
	Epworth Poly Clinic	No. of patients				22,440	38,000	42,000
		No. at post				5	5	4
		Attendance per nurse				4,488	7,600	10,500
Mid-wives	Gweru Provincial Hospital	No. of patients	22,417	23,110	22,991	26,710	28,539	31,993
		No. at post	20	22	22	20	18	18
		Attendance per midwife	1,121	1,050	1,045	1,336	1,586	1,777
	Epworth Poly Clinic	No. of patients				10,800	14,362	21,065
		No. at post				10	8	9
		Attendance per midwife				1,080	1,795	2,341
Pharm-acists	Gweru Provincial Hospital	No. of patients	169,662	173,680	194,579	179,633	194,540	197,620
		No. at post	2	2	1	1	1	1
		Attendance per pharmacist	84,831	86,840	194,579	179633	194,540	197,620
	Kadoma District Hospital	No. of patients			20,099	21394	46,422	35,308
		No. at post			1	1	1	1
		Attendance per Pharmacist			20,099	21,394	46,422	35,308

significantly as one moves to the district and provincial health institutions. The study also established that less qualified staff (namely nurse aides) are carrying out nursing duties at health centres owing to the shortage of health professionals.

The migration of skilled health professionals from the country has also adversely affected the quality of care offered in the health institutions. This confirms the findings of other studies which reported falling standards of care, which include 'uncaring and abusive' attitudes towards patients.[21] This can generally be attributed to low morale resulting from excessive workload associated with the stress of dealing with so many dying patients. Consequently, the quality of care has been significantly affected, a factor arising directly from the shortage of health professionals due to emigration.

The shortage of suitably qualified health professionals in the country's public health institutions has increased the workload of those who remain (Table 12). For instance, half of the respondents attend to more than 20 patients per shift while only 9.5% attend to less than five per shift. As many as 78% of the health professionals interviewed expressed dissatisfaction over the number of patients they attend to per day which they regard as extremely high. They blamed emigration for the increase in the workload. In this case, the migration of health staff is seen as both a cause of ongoing migration (by increasing workload of remaining health professionals) and its effect (due to the reduction of available health professionals).

Table 12: Patient Attendance Rates

Number of clients attended to per shift	No.	%
Less than 5	22	9.5
6-10	21	9.1
11-15	37	16.0
16-20	35	15.2
More than 20	116	50.2
Satisfaction with number of clients attended to		
Yes	51	22.1
No	180	77.9
N = 231		

The reduction in the consultation time available to patients produces hurried diagnoses and prescription of treatment. This obviously affects the quality of care available to patients. Furthermore, the reduction in consultation may lead to a wrong diagnosis, a fact which may

endanger the lives of patients. Interviews with health professionals revealed that more than half (55%) took less than ten minutes to attend to a single patient while only 16.5% took more than 20 minutes to attend to an individual patient (Table 13).

Table 13: Time Spent with Patients

Average time spent on an individual patient	No.	%
Less than 5 minutes	43	18.6
6-10 minutes	87	37.7
11-15 minutes	35	15.2
16-20 minutes	28	12.1
More than 20 minutes	38	16.5
Satisfaction with the time spent per patient		
Yes	65	28.1
No	166	71.9
Do you personally offer services that should ideally be attended to by another member of the team?		
Yes	143	61.9
No	88	38.1
N = 231		

The focus group discussions confirmed the reduction in the consultation time available to patients as a result of shortage of staff. One participant pointed out that: "The shortage of nurses at the clinic means that patients have to wait for a long time before receiving medical treatment. In fact, some patients even die while they are queuing to receive treatment. When a patient eventually receives treatment, consultation is usually done hurriedly as the nurses work at a fast pace so as attend to a multitude of other patients waiting to receive the same service."

The health professionals expressed dissatisfaction about the average time they spend on an individual patient (63.2%). More than half of the respondents (55.8%) are sometimes forced to offer services that should ideally be offered by another member of the health team. In this category, 66% of the doctors and 55% of the nurses indicated that they sometimes offer services that they are not supposed to render, but do so because of the absence of specialised personnel. This has two main consequences: (a) it increases the workload of the health professionals concerned; and (b) the lives of patients may be endangered as some unqualified health professionals may end up performing more specialised procedures.

In Zimbabwe, there are clear differences between the rural and urban areas. Rural areas, in particular, lack basic infrastructure such as all-

weather roads, electricity and clean water supplies. In addition, rural health centres in Zimbabwe often lack basic drugs and equipment and are understaffed. This translates into a heavy workload for the few health professionals posted in such areas. Because of such factors, rural-urban movement of nurses within the public sector is common and consequently the staffing situation in rural health institutions continues to worsen. Some nurses in rural areas also move to private health institutions in urban areas, a move which entails both change in geographical location (rural to urban) and employer (public to private sector).

OFFICIAL POLICY RESPONSES

The study sought to establish the factors that might help the retention of health professionals in the country. From the point of view of the professionals themselves, the most important factors that would influence them to remain are better salaries (76.6%) and fringe benefits (71.4%) (Table 14). Other important factors cited include a more pleasant and caring working environment (69.3%), improved facilities and resources in the health services of the country (63.3%), a more reasonable workload (59.7%) and more accessible education and training opportunities (50.6%).

Table 14: Factors Motivating the Retention of Health Professionals

Factor	%
Better salaries	76.6
Better fringe benefits	71.4
A more pleasant and caring working environment	69.3
Improved facilities and resources in the health services of the country	63.6
A more reasonable work load	59.7
A more peaceful social environment in the country	51.5
More accessible education and training opportunities	50.6
Better working relationships in the public health sector	48.9
Better quality education and training in my professional field	45.9
The provision of adequate day care facilities for children of employees	43.7
Better leadership in the health sector	43.3
The appointment of more competent health service managers	42.4
Innovative training opportunities such as distance education	34.6
N = 231	

The informants in key positions indicated that better salaries are the best incentive to retain skilled health professionals in the country. A substantial proportion believe that offering better incentives could reduce outward migration. Additional factors cited included a stable political climate, good working conditions, prospects for further education, redress of the macro-economic environment and a well-developed human resources policy.

The high rate of emigration from Zimbabwe has led the government to adopt several measures to try and contain the problem. Firstly, the government has introduced bonding of newly-qualified health professionals. All the nurses and doctors that started training in 1997 are bonded by the government for three years. In the case of doctors, they are given their academic certificates while their practising certificates are withheld for three years. Some newly-qualified doctors reportedly leave with their academic certificates for countries such as South Africa where practising certificates are not mandatory.[22] Other health professionals may serve the duration of the bonding period, after which they are free to make their own decisions regarding where they want to work. Bonding clearly acts as a delaying mechanism to emigration but does not address the root causes of migration. Health professionals may dutifully serve the period of bonding and then migrate to other countries at the expiry of their bonding period. Bonding itself can also have a negative impact, increasing dissatisfaction levels amongst health professionals.

Secondly, fellowship and scholarship programmes, as well as advanced training programmes, have been introduced to enhance the capacity of the health professionals in the discharge of their services. They are also meant to reduce the migration of health professionals wishing to further their studies abroad. An Institute of Continuing Health Education (ICHE) was established to cater for the specialist postgraduate training and continuing education needs of those in the medical field at the University of Zimbabwe's School of Medicine. ICHE provides all forms of continuing medical education not only for doctors, but for all categories of health professionals: certificated education, skills advancement, update as well as skills renewal. ICHE has achieved considerable success in spite of budgetary constraints.

Thirdly, salary reviews were introduced to cushion health professionals from the harmful effects of the country's high cost of living. However, with the current hyper-inflation prevailing in the country, the salary reviews are constantly lagging behind, thereby negatively affecting the livelihoods of health professionals.

Fourthly, call allowances were introduced to allow professionals to work extra hours due to staff shortages. There are better call allowances in rural than urban areas. Call allowances have, to a certain extent,

aided in retaining staff, but lately there have been complaints and junior doctors have gone on strike over unpaid allowances. Government's policy that call allowances should not exceed the salary of the health professionals has led to clashes with members of the health team whose overtime working hours exceeded their normal working hours. However, as noted above, the country's high rate of inflation continues to erode any gains that might have been made as far as readjustments of the salaries of health professionals are concerned. While these measures may achieve commendable results in the short term, they cannot be adopted as a permanent solution to the crisis.

Finally, performance management has been introduced in the health sector. According to the informants in key positions, performance management has led to greater professional acknowledgement. However, other informants were of the opinion that the system had largely failed because the results are not being implemented because of stiff resistance to the policy within the system. Hence, it was argued that the implementation of policies aimed at retaining staff would not achieve the desired results as long as the question of low remuneration is not addressed.

The severe shortage of health professionals, particularly in disadvantaged rural areas has prompted the govemment to recruit foreign health professionals. Zimbabwe has an agreement with Cuba in this regard. In 2002 there were 117 Cuban doctors practicing in the country. Media reports also indicate that the govemment is looking to other countries such as the Democratic Republic of Congo for health professionals, particularly doctors and pharmacists.

Most key informants were sceptical about the role played by foreign health professionals. While some argued that foreign doctors help to ease staffing shortages and improve the quality of care, many said that teamwork is difficult due to language barriers and only leads to temporary relief as the workers come on short contacts. This is particularly true for the Spanish-speaking Cuban doctors who are posted to rural health institutions in the country where they face problems with the local communities who are mainly Shona-speaking. Consequently, they are hindered from discharging their duties fully because of communication problems. The French-speaking health professionals from the DRC are likely to face similar problems. Furthermore, the fact that the Cuban doctors have to return annually to their home country at the government's expense presents a significant drain on the country's scarce foreign currency resources.

The community respondents indicated that they had not made any concerted efforts to try and retain health staff at their local health institution. They believe that it is only the government that can retain skilled health staff at certain geographical locations. They also lamented

the lack of consultation between them and the government, a factor which has sidelined them from making meaningful contributions to the planning and implementation of developmental activities at the clinic. These views are typical of many rural communities in Zimbabwe who, through time, have developed a high level of dependency on the government. However, some communities are active in improving the welfare of health professionals posted in their area. These include the construction of decent accommodation for health professionals and carrying out maintenance work around the hospitals/clinics. The community respondents were further probed on how best to retain skilled health workers in their community. They thought that one way to retain health staff in the community would be through the provision of good quality accommodation and transport. In this regard, some thought government should offer health workers loans to buy cars and houses.

Can foreign-based health professionals be enticed back to Zimbabwe? The experience of the IOM's Return of Qualified African Nationals Programme (RQAN) is instructive.[23] This programme encouraged the return and reintegration of qualified African professionals. In Zimbabwe, the RQAN programme began in 1983. Up to 1997, a total of only 427 Zimbabwean professionals residing abroad had been assisted to relocate to Zimbabwe. From 1995 to 1998, a mere 27 professionals were relocated back to the country under the RQAN. Eleven of these were medical doctors, two were pharmacists and one was a dentist. This programme had a limited impact at a time when political and economic conditions in Zimbabwe were less chronic than they are today. One could safely hypothesize that the programme would be even less effective at the present time.

More research is needed on the extent to which departed health professionals maintain financial contacts with home and the volume of remittances sent back to relatives still in the country. Anecdotal evidence suggests that the amount is likely to be sizable.

CONCLUSION

This paper has provided an overview of the trends and effects of the migration of health professionals from Zimbabwe. Most of the country's public health institutions are grossly understaffed and the skeletal staff remaining is reeling under heavy workloads. Both urban and rural health institutions have been affected by emigration, but the rural areas have been hardest hit and are being served by un- or under-qualified health staff. The situation is much better in urban areas which have alternative sources of medical healthcare in the form of private health institutions. Besides offering better services

to patients, albeit at a higher fee, the private health sector also provides an escape route for the dissatisfied public health sector professionals who find the salaries offered by the public sector unattractive. In fact, the migration of health professionals to the private sector has been viewed as partially responsible for the decline in the quality of health-care services offered by the public sector. The argument might be made in the context of massive out-migration that this "safety valve" does at least keep medical professionals in the country. Professionals (especially nurses and junior doctors) who have failed to move to the private sector are engaged in part-time work in the private sector and are often exhausted by the time they attend their shifts at their health institutions.

The overall picture of health professionals employed nationally has been one of decline. Notwithstanding the fact that health professionals have been moving to the private sector, others have chosen to remain in the public sector for a number of reasons. The findings suggest that some professionals are using private sector employment as a stepping stone to obtaining the funds for purchasing airfares before moving overseas. It has been observed that the United Kingdom is the major destination for Zimbabwean trained nurses and pharmacists, while doctors have mostly migrated to Botswana and South Africa.

The problem of HIV/AIDS has been highlighted especially in as far as it impacts on the workload of health professionals. The disease has added to the strain experienced by health professionals due to its chronic nature. However, what is particularly worrying is the fact that some health professionals, especially those working in rural areas, allege that their health institutions were not taking adequate measures to protect them from the risk of contracting HIV/AIDS. Hence, a combination of heavy workloads and lack of protection have acted as a push factor for the migration of health professionals from the disadvantaged parts of the country.

The study also assessed current government policies aimed at retaining health professionals in the country and found them to be largely ineffective. For instance, initiatives to attract health professionals to marginal (rural) areas are not yielding the desired effects as the professionals consider them inadequate. The loopholes in some of the current policies have also been exposed. There is clearly a need to draw up policies that are effective in retaining current staff and re-attracting emigrants. The findings of this study will hopefully positively aid policy-makers in making informed policy decisions which would alleviate the plight of public sector health professionals.

The high emigration rate of Zimbabwean health professionals makes more urgent the need for the adoption of proper remedial solutions.

However, it needs to be acknowledged that migration, like globalisation, is an integral component of the modern world. A country can no longer be isolated from global events and skilled professionals are no exception. Hence, govemments need to work multi-laterally in the formulation of policies that can manage the process.

The most important push factors identified in the study are political and economic factors. Hence, solving the current political problems facing the country is the first step towards normalising events. The current problems facing Zimbabwe have largely been a function of the political events that occurred in the late 1990s. The alleged absence of the rule of law in the country saw donor support dwindling, leading to the current foreign currency shortages. Furthermore, lack of international support for the government's agrarian programme (coupled with drought in the 2002/03 season) saw the country's food base declining. Food scarcity in the shops has resulted in a high cost of living, leaving most professionals struggling to survive. Currently, the impasse between the ruling and opposition party threatens to worsen the situation, as inflation continues to rise. Solving the political crisis will go a long way towards kick-starting the economy and restoring normality in the country.

Economic factors were cited as the major reasons for the migration of health workers from the public sector. Within the country, the salaries offered in the public sector are far below those offered in the private sector. This imbalance in salary levels has acted as a pull factor for the professionals employed in the public sector. In this regard, it is recommended that the government look into the salary structures of health professionals so as to redress this anomaly. Once the professionals move from the public to the private sector, it is easier for them to engage in long-distance migration.

Public-to-private sector migration of health workers closely compares to the rural-urban drift of skilled health professionals. Owing to a wide range of factors, health professionals have found conditions in the rural areas unattractive. Thus, conditions need to be improved for health workers employed in rural areas. In this vein, the govemment should introduce economic (monetary) incentives to help lure health professionals to such locations. Alternatively, a programme can be put in place that allows newly trained professionals (including nurses) to serve their period of bonding in rural health institutions.

It is recommended that the government and its partners develop a culture of record-keeping in health institutions. Proper policy prescriptions can only be offered in the presence of reliable data sources. The biggest obstacle in the research process was encountered in collecting quantitative data. The MoHCW did not have up to date records, and data for categories such as pharmacists and dentists was not available.

Hence, a national database has to be set up which provides details of health professionals employed nationally in all health institutions. All the health institutions could be required to submit figures annually to feed into the database. Such information would help policymakers to monitor trends in each of the categories of health workers as well as assisting in identifying poorly-staffed health institutions.

Lastly, the plight of health workers needs to be examined in detail. While poor salaries might be one of the factors leading to the migration of health professionals from the public sector, their working conditions also need to be improved. During the research process it emerged that some of the health professionals work in a climate of fear of contracting the deadly HIV/AIDS virus. Hence, more preventive measures should be taken to reduce the stress associated with the fear of exposure of health professionals to HIV/AIDS. Protective clothing has to be made available to health professionals at all times so as to reduce their risk of contracting the disease.

In conclusion, the migration of skilled professionals from the country needs to be addressed as a matter of urgency. Arresting the current levels of skilled health professionals' migration from the country should be one of the major goals of the government. It needs to be appreciated that a well-developed human resource base is a prerequisite for economic growth and development. Thus, the research calls for the adoption and the implementation of an integrated policy that will see the retention of skilled health professionals in the country so that national goals and aspirations can be achieved.

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ENDNOTES

1 W. Carrington and E. Detraglache, *How Big Is the Brain Drain?* IMF Working Paper No. 98/102, 1998; D. McDonald and J. Crush, eds., *Destinations Unknown: Perspectives on the Brain Drain in Southern Africa* (Pretoria: Africa Institute, 2002); R. Iredale, "The Migration of Professionals: Theories and Typologies" *International Migration* 39(5) (2001): 7-26; S. Commander, M. Kangasniemi and A. Winters, "The Brain Drain: Curse or Boon" In R. Baldwin and L. Winters, eds., *Challenges to Globalization* (Chicago: University of Chicago Press, 2003).

2 T. Fadayomi, "Brain Drain and Brain Gain in Africa: Causes, Dimensions, and Consequences" In A. Adepoju and T. Hammer, eds., *International Migration in and from Africa: Dimensions, Challenges, and Prospects* (Stockholm: Population, Human Resources and Development in Africa, 1996); D. Teferra, *Brain Drain of African Scholars and the Role of Studying in the United States* (Boston: Centre for International Higher Education, 2000); S. Tapsoba et al, eds., *Brain Drain and Capacity Building in Africa* (Dakar: ECA/IDRC/IOM, 2000).

3 World Bank, *World Development Report: Workers in an Integrating World* (Washington: World Bank, 1995).

4 A. Oyowe, "Brain Drain Colossal Loss of Investment for Developing Countries" *The Courier* ACP-EU, 159 (1996): 59-60.

5 W. Gould, "Government Policies and International Migration of Skilled Workers in Sub-Saharan Africa" *Geoforum*, 19(4): 433-445.

6 J. Crush, "The Global Raiders: Nationalism, Globalization and the South African Brain Drain" *Journal of International Affairs*, 56 (2002): 147-72; M. Scott et al. "Brain Drain or Ethical Recruitment? Solving Health Workforce Shortages with Professionals from Developing Countries" *MJA*, 180(2004): 174-6.

7 WHO, *Report of the Special Working Group on WHO's Constitution and the Brain Drain Problem in Africa* (Brazzaville: WHO/AFRO, 1997); P.E. Bundred and C. Levitt, "Medical Migration: Who Are the Real Losers?" *Lancet*, 356(9225) (2000): 245-6; G. Bloom, and H. Standing, "Human Resources and Health Personnel" *Africa Policy Development Review*, 1(1) (2001): 7-19; J. Huddart and O. Picazo, *The Health Sector Human Resource Crisis in Africa* (Washington: USAID, 2003); D. Davlo, "The Brain Drain and Retention of Health Professionals in Africa" Report for Regional Training Conference on Improving Teritiary Education in Sub-Saharan Africa, Accra, 2003.

8 R. Gaidzanwa, *Voting with their Feet: Migrant Zimbabwean Nurses and Doctors in the Era of Structural Adjustment* (Uppsala: Nordiska Afrikainstitutet, 1999); D. Tevera and J. Crush, *The New Brain Drain from Zimbabwe*, SAMP Migration Policy Series No. 29, 2003.

9 United Nations Integrated Information Networks (IRIN), 10 April 2001;

Zimbabwe Independent, 5 January 2001, *The Insider*, 26 November 2001.

10 CSO, *Zimbabwe- Facts and Figures* (Harare: CSO, 1999); CSO, *Zimbabwe - Facts and Figures 2001/2002* (Harare: CSO, 2003).

11 The Employers Confederation of Zimbabwe estimated in 2000, that of 1,200 new doctors trained between 1990 and 2000, only 360 (30%) were practising in Zimbabwe; *Financial Gazette*, 21 December 2000.

12 Gaidzanwa, *Voting With Their Feet*; R. Ndlovu et al. "The Situation of Nursing in Zimbabwe" *Africa Policy Development Review*, 1(1) (2001): 41-73.

13 *The Daily News*, 17 September 2001

14 I. Hardill and S. McDonald, "Skilled International Migration: The Experience of Nurses in the United Kingdom" *Regional Studies*, 34 (7) (2000): 681-92.

15 D. S. Kline, "Push and Pull Factors in International Nurse Migration" *Joumal of Nursing Scholarship*, 35(2003): 107-111.

16 S. Commander, M. Kanagasniemi and A. Winters, *Is the Medical Brain Drain Beneficial? Evidence from Overseas Doctors in the UK*, London Business School Working Paper, 2003.

17 *Sunday Mail*, 10 June 2002; Anon, "How is the Crisis in Zimbabwe Affecting Pharmacy in the Country?" *The Pharmaceutical Journal*, 268(2002): 582.

18 Gaidzanwa, *Voting with Their Feet.*

19 UNAIDS, *HIV/AIDS in Zimbabwe- A USAID Brief* (Harare: USAID/Zimbabwe, 2002).

20 Republic of Zimbabwe, *Commission of Review into the Health Sector, Key Messages Report* (Harare: Government of Zimbabwe, 1999); C. Chasokela, "Policy Challenges for the Nursing Profession" *Africa Policy Development Review*, 1(2001): 1-6.

21 D. Mutizwa-Mangiza, *The Impact of Health Sector Reform on Public Sector Health Worker Motivation in Zimbabwe* (Bethesda: Abt Associates, 1998).

22 Gaidzanwa, *Voting with Their Feet.*

23 International Organization for Migration (IOM), *Zimbabwe: Return of Qualified African Nationals (RQAN) - Placement Status* (Harare: IOM, 1997).

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