Retention incentives for health workers in Zimbabwe

MJ Chimbari, D Madhina, F Nyamangara, H Mtandwa and V Damba

National University of Science and Technology

With the Regional Network for Equity in Health in East and Southern Africa (EQUINET),
the University of Namibia, University of Limpopo
in co-operation with the East, Central and Southern African Health Community (ECSA-HC)

DISCUSSION PAPER 65

September 2008

With support from SIDA (Sweden)

Table of contents

Cite as: Chimbari MJ, Madhina D, Nyamangara F, Mtandwa H, Damba V (2008) 'Retention incentives for health workers in Zimbabwe,' *EQUINET Discussion Paper Series 65*. NUST/ UNAM, U Limpopo, ECSA-HC, EQUINET: Harare.

Executive summary

This paper investigates the impact of the framework and strategies to retain critical health professionals (CHPs) that the Zimbabwean government has put in place, particularly regarding non-financial incentives, in the face of continuing high out-migration. The out-migration of CHPs to countries in the region or overseas remains one of Zimbabwe's most pressing problems. The movement of staff is not only from lower to higher levels in the public sector, or from public to private institutions. Now even lower-level staff are leaving in increasing numbers for other countries in the region or beyond. Their departure confronts the assumption that these newly trained staff would replace experienced staff who had already emigrated. The paper examines the impacts of non-financial retention incentives being applied, and makes recommendations aimed at enhancing the monitoring, evaluation and management of the incentives by the Zimbabwe Health Service Board (ZHSB), the institution responsible for administering them.

The work was implemented within the regional programme on incentives for health worker retention in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA). The programme is co-ordinated by University of Namibia, Namibia, with support from University of Limpopo and Training and Research Support Centre, and the ECSA Technical Working Group on Human Resources for Health. The study sought to investigate the causes of migration of health professionals; the strategies used to retain health professionals, how they are being implemented, monitored and evaluated and their impact, in order to make recommendations to enhance the monitoring, evaluation and management of non-financial incentives for health worker retention.

The ZHSB's strategic plan for 2005-2010 provides a good framework for monitoring and evaluating the incentives programme for CHPs in Zimbabwe, but faces problems with availability of data for its implementation. While efforts are underway to strengthen data collection, this constraint also affected the study. Our research included a desk review, field data collection through a non-interventional, descriptive cross-sectional survey and a review workshop. Our field study included public, private and faith-based health institutions from urban and rural settings in three administrative provinces (Mashonaland West, Matebeleland South and Masvingo) and two major cities (Harare and Bulawayo) in Zimbabwe, and focused on critical health professionals (CHPs), namely doctors, nurses, pharmacists, radiographers, laboratory technicians, dentists, opticians, nutritionists and therapists. Key informant interview was done in each of the participating stakeholder institutions, with 21 informants interviewed. A questionnaire addressing all research questions was administered to representatives of each category of CHPs, with 196 questionnaires completed in total. Five focus group discussions (FGDs) were held with different groups of trainees, focusing on their perceptions of the retention packages, with up to 20 participants in each FGD. A half-day workshop was held to discuss the findings.

The field survey results showed that Zimbabwe is losing the most experienced CHPs, but that even newly qualified staff aspire to migrate to gain experience. CHPs are well positioned in terms of career structure and those that have diversified by venturing into non-medical business ventures appeared to be less likely to migrate. Migration was found to be taking place at all levels (primary, district, provincial, central and private sector) of the health delivery system. Most CHPs from Zimbabwe migrate to South Africa, Botswana, Namibia, Australia, United Kingdom and New Zealand.

The major factor driving out-migration was found to be the economic hardship that the CHPs are facing due to the deterioration of the country's economy. Other factors identified, including poor remuneration, unattractive financial incentives and poor working

conditions, relate directly to this. The efforts of the ZHSB to mitigate this have been frustrated by a number of challenges. Hyper-inflation has rapidly eroded the value of the financial retention incentives awarded by the ZHSB, while negative economic growth rate and funding limitations have limited construction of and availability of staff housing, the award of vehicle use entitlements to deserving staff and the operation of the vehicle loan scheme, the latter becoming inoperative in 2006. A national shortage of fuel added to transport costs, eroding the transport allowances awarded to staff without vehicles.

Some practices added to falling morale: Bonding staff to retain them is unpopular and tends to promote desertion of staff without giving the contractual notice period. While not rejected as a concept, staff view it as punitive in the current context of the unsustainable remuneration packages experienced during the bonding period. The selective award of allowances to health workers has a demoralising effect on those that do not receive them, particularly in circumstances where the working hours and conditions are similar. The exclusion of CHPs in the Ministry of Higher and Tertiary Education from the mandate of the ZHSB has created serious disparities in remuneration between staff in the ministry and those under the ZHSB.

The retention package offered by the ZHSB appear not to have much impact on the ground. Many interviewees indicated that the package was not attractive and some said they were not aware of it. The private and municipal health institutions seemed to have more functional retention packages than the public (government) health institutions, whose budgets made implementation of the packages difficult. Many factors undermining implementation of the package are beyond the control of the ZHSB. While the ZHSB has a clear implementation and monitoring strategy, it faces challenges in sustaining the retention package due to funding. It was unclear how government would focus on the needs of CHPs when there are many critical staff in other sectors deserving attention.

There is some latitude for review, and the paper makes recommendations, drawing also on options raised in the field study. With the current hyperinflationary environment, we suggest that non-financial incentives that are not directly eroded by inflation could be given greater attention, including in partnership with non government organisations and communities served by CHPs. Retention strategies should target all staff categories, including those in training institutions, given the tendency for staff at all levels to migrate. Staff working under similar conditions should get the same allowances on a sliding scale based on their grades. Remuneration of CHPs in the Ministry of Higher and Tertiary Education and those under the ZHSB should be harmonised. Efforts could be made to improve the professional mix in the hierarchy of the Ministry of Health and Child Welfare, and modules on management included in the training curriculum of health professionals. The bonding of staff as a retention measure should be reviewed so that it does not appear to be punitive. Development of defined career paths and opportunities for continuing education were considered to be better 'bonding' strategies, which, while not legally binding, were already more effective in retaining staff.

We suggest that managing health worker incentives calls for the ZHSB to have greater decision making latitude. This would need to be further explored and may involve legal review. Further the efforts to improve data collection by the ZHSB need support. The ZHSB should be able to document the actual number of CHPs leaving the country and the countries they go to. This calls for multi-country arrangements that will facilitate exchange of information on the registration of foreign CHPs in participating countries. The World Health Assembly Code that is being developed may help address this problem, but will need to go beyond the code to address the problems in operationalising such arrangements, including strengthening the databases at country level to support this information exchange.

1. Introduction

Public health systems in southern African countries have been weakened through the loss of health professionals moving from the public to the private sector within the country or leaving the country to work elsewhere in the region or to work in developed countries like the United Kingdom (UK), United States of America (USA), Canada and Australia (Lancet editorial, 2005; WHO, 2005; Eastwood, Conroy, Naicker, West, Tutt and Plange-Rhule, 2005; Mutiswa and Mbengwe, 2000; Chikanda, 2004). The causes for this migration (often called the 'medical brain drain') and efforts that are being made by countries to retain health professionals have been generally documented (EQUINET SC, 2007) and were a subject of intense debate at the First Global Forum on Human Resources for Health held in Kampala, Uganda from 2 to 7 March 2008.

Available data shows that some countries have taken measures to minimise this medical brain drain (Dambisya, 2007). Numerous international and regional agreements address retention and migration of critical staff in the health sector (First Global Forum on Human Resources for Health, 2008; WHA, 2006; AU Health Minister's Decisions on HR, 2005; NEPAD, 2001). The Fifty-ninth World Health Assembly held in May 2006 directed the World Health Organisation (WHO) Director-General to, among other things, provide technical support to member states, as needed, in their efforts to revitalise health training institutions and rapidly increase their health workforce, as well as encourage member states to engage in training partnerships intended to improve the capacity and quality of health professional education. The Southern Africa Development Community Human Resources for Health Strategic Plan (SADC-HRH) (2006-2019) requires governments to conduct a situational analysis and provide a report on the magnitude and impact of the brain drain. They must also develop and implement policies and strategies to attract workers to the public health sector and retain them, such as improving their working conditions. EQUINET and the East, Central and Southern Africa Health Community (ECSA HC) have committed funds to further these objectives, as listed in the SADC HRH strategic plan, by supporting activities that seek to provide country-level data on what individual governments are doing to retain health professionals.

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA) is implementing a programme of research and policy dialogue on incentives for health worker retention in east and southern Africa. The programme is co-ordinated by University of Namibia, Namibia, with support from University of Limpopo and Training and Research Support Centre, and the ECSA Technical Working Group on Human Resources for Health. Building on consultations and methods workshops held in 2006 and 2007, this programme has supported research in east and southern Africa to inform policy development and strengthen the management and evaluation of incentives for the retention of health workers, particularly non-financial incentives. The research reported here was implemented within this programme.

On the basis of information available through independent studies (Mutiswa and Mbengwe, 2000; Chikanda, 2004) and consultations with the Zimbabwe Health Service Board (ZHSB), the government of Zimbabwe has, through the ZHSB, made some interventions to retain critical health professionals (ZHSB, 2006). They took a general approach that took into account push and pull factors (factors that motivate workers to leave) and the stick and stay factors (factors that motivate workers to stay) in the formulation of the interventions. In this study, we have systematically assessed the causes of migration and the efforts being made by the Zimbabwean government to retain health professionals (HPs), using a variety of methods.

Our main objective was to determine and assess the impact of health worker retention incentives instituted by both the Zimbabwe government and non-government sector (faith-based organisations and private facilities). We sought to address the following research questions:

- What are the reasons for the migration of health professionals?
- What strategies are being used to retain health professionals?
- How are these strategies being implemented?
- How are they being monitored and evaluated?
- What impact have they had?
- How sustainable are they?
- What guidelines can be drawn from the lessons learned from the study?

These questions formed the basis of our specific objectives, namely to:

- determine the causes of the migration of health professionals;
- determine the strategies used to retain health professionals;
- document how the strategies are being implemented;
- document how they are being monitored and evaluated;
- assess the impact that they are having;
- assess their sustainability; and
- make recommendations to the ZHSB to enhance the monitoring, evaluation and management of non-financial incentives.

While the World Health Report defines the health workforce to include 'all people engaged in actions whose primary intent is to enhance health' (2006:2), We focused on the categories of health workers where attrition and its impact have been greatest. According to the ZHSB Annual Report (2006), the categories experiencing the highest vacancy rates were medical doctors, nurses and pharmacists. For the purposes of this study, the following health professionals were added to the above list on the basis of the critical service they provide and vacancy rates levels: radiographers, laboratory technicians, dentists, opticians, nutritionists and therapists. Throughout this report, the workers in these categories of health professionals will be collectively referred to as 'critical health professionals' (CHPs).

2. Methodology

This study was conducted in various health institutions within Zimbabwe, including public, private and faith-based health institutions (see *Table 1*).

A non-interventional, descriptive cross-sectional survey study design was adopted, focused on CHPs. To obtain a cross-country overview of the subject under study, the study sites included urban and rural settings in three administrative provinces (Mashonaland West, Matebeleland South and Masvingo) and two major cities (Harare and Bulawayo). *Figure 1* shows the provinces of Zimbabwe, including the locations of major cities.

Table 1: Health institutions assessed in this study, 2007

Name of institution	Type	Location
Ministry of Health and Child Welfare – Head Office	Public	Harare
Central Statistics Office	Public	Harare
Health Service Board	Public	Harare
Parirenyatwa Group of Hospitals	Public	Harare
Avenues Clinic	Private	Harare
Kadoma District Hospital	Public	Mashonaland West
Sanyati Mission Hospital	Faith-based	Mashonaland West
Mpilo Hospital	Public	Bulawayo
Bulawayo City Health Department	Local Authority	Bulawayo
Mzilikazi Poly-clinic	Local Authority	Bulawayo
Princes Margaret Rose	Local Authority	Bulawayo
Mater Dei Hospital	Private Faith-based	Bulawayo
Gwanda Provincial Hospital	Public	Matebeleland South
Gwanda Multi-disciplinary Training School	Public	Matebeleland South
Colin Saunders Hospital	Private	Masvingo
Hippo Valley Estates Health Division	Private	Masvingo
Chiredzi District Hospital	Public	Masvingo
University of Zimbabwe, College of Health Sciences, Medical School	Public	Harare
Nurses Council	Public	Harare
Medical Laboratory and Clinical Sciences Council	Public	Harare
Allied Health Professions Council	Public	Harare
Medical Rehabilitation Practitioners Council	Public	Harare
Environmental Health Professions Council	Public	Harare
Pharmacists Council	Public	Harare
Medical and Dental Practitioners Council	Public	Harare

Figure 1: Zimbabwe's administrative provinces and major cities

KEY

1. Bulawayo (city)
2. Harare (city)
3. Manicaland
4. Mashonaland Central
5. Mashonaland East
6. Mashonaland West
7. Masvingo
8. Matebeleland North
9. Matebeleland South
10. Midlands

Documents pertaining to the working conditions of health professionals, including policy issues, were collected from the Zimbabwe Health Service Board (ZHSB), Central Statistics Office (CSO) and the Ministry of Health and Child Welfare (MoH&CW) and analysed to understand staff attrition and retention issues. In order to put the study into regional and global context, relevant documents from regional organisations, like the

Southern African Development Community (SADC), and international organisations, like WHO and Global Health Workforce Alliance (GHWA), were also analysed.

In each of the stakeholder institutions that participated in the study, a key informant was interviewed face-to-face, using an interview guide with questions addressing all the research questions. (A key informant was defined as a senior member of staff familiar with CHP issues, such as directors, medical officers and board members.) A total of 21 informants were interviewed. A questionnaire addressing all research questions was administered to representatives of each category of CHPs. The sample size for each category depended on the availability of staff on the day of the interview. However, we attempted to interview as many eligible CHPs as possible. A total of 196 questionnaires were completed.

Five focus group discussions (FGDs) were held with different groups of trainees, namely primary care nurses (at Sanyati Mission Hospital) and general nurses (at Sanyati Mission Hospital and Parirenyatwa Central Hospital), environmental health technicians (at a multi-disciplinary training school) and fifth-year medical students at the University of Zimbabwe College of Health Sciences. The FGDs focused on trainees' perceptions of retention packages. Each FGD contained no more than 20 participants. While most studies recommend no more than 12 participants in an FGD, it was not possible to comply with this ruling, as that would have caused disruptions in the normal routine of the participants. Nonetheless, each FGD consisted of a homogeneous group of participants. The FGDs were facilitated by one researcher, with another taking notes. An FGD guide was used to keep the discussions focused.

After collecting data, a half-day workshop was held to discuss a preliminary report on the data. It was attended by representatives of organisations who participated in the study (sample) and other stakeholders. In the workshop we presented background to the study, and the study methodology and research findings, then had a general discussion of all presentations and a final discussion of additional issues to enrich the report. The final discussion focused on weaknesses and strengths of the current incentives package, additional incentives (both financial and non-financial) not included in the report, suggestions on how the Health Service Board could be strengthened to improve conditions of service for CHPs specifically and the health delivery system in general, and suggestions for mechanisms that could be put in place for Zimbabwe to benefit from the out-migration of CHPs.

3. Results

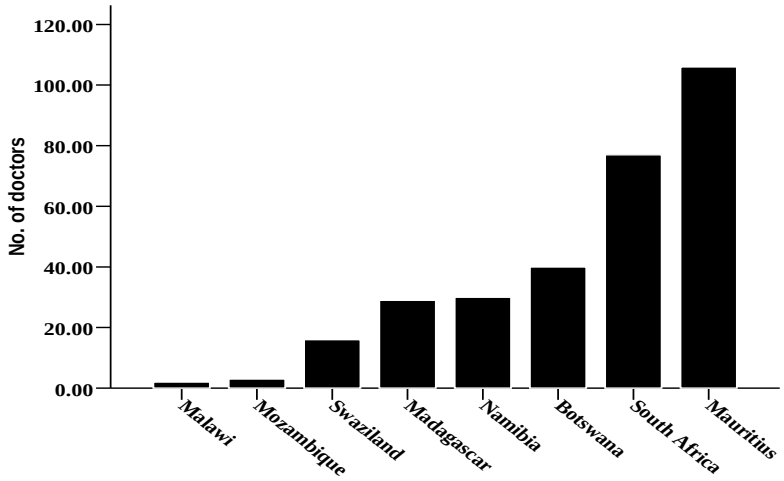
In this section, we present secondary data from the document analysis (including international, regional and country-level analyses of health worker incentives) and primary field data from key informant interviews, questionnaires, FGDs and workshop.

3.1 Results of the document analysis

Our analysis of documents reporting on health professionals at regional and international levels revealed that there is a serious global shortage of health professionals, with demand far exceeding supply (Lancet editorial, 2008; Robinson and Clark 2008; EQUINET SC, 2007; Pillay, 2007; Eastwood et al, 2005). While there is consensus that the movement of professionals in any field is not a problem in itself, there is shared concern that the movement of CHPs is skewed (from developing countries to developed countries), gradually crippling health delivery systems in developing countries. Some argue that developed countries are failing to meet their domestic demand for health professionals, deliberately avoiding the cost of training and instead preferring to invest in

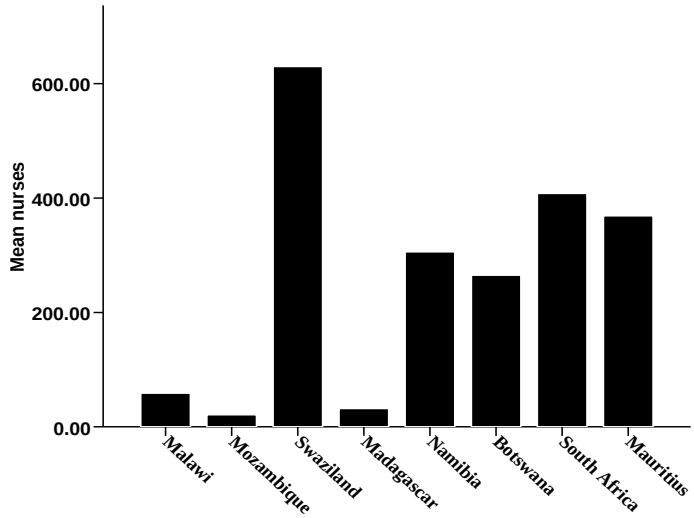
creating pull factors, which attract workers from foreign countries (McIntosh T, Torgerson and Klassen, 2007). Out-migration also occurs in developed countries, but does not negatively impact on their health systems. In the case of the United Kingdom, CHPs migrate to the United States, Canada, Australia or New Zealand (Pillay, 2007). The global imbalance in the distribution of health professionals is well documented (WHO, 2006, 2007; EQUINET SC, 2007). According to Robinson and Clark, 'Africa carries 25% of the world's disease burden yet has only 3% of the world's health workers and 1% of the world's economic resources to meet that challenge' (2008:691). There are also some imbalances in the distribution of CHPs within sub-Saharan Africa, as indicated in *Figures 2* and *3*, based on 2004 statistics.

Figure 2: Doctors per 100,000 population in some sub-Saharan countries, 2004



Adapted from: WHO, 2005

Figure 3: Nurses per 100,000 population in some sub-Saharan countries, 2004



Adapted from: WHO, 2005

Analysing data from 16 sub-Saharan countries (see *Table 2*), it appears that countries with a higher ratio of doctors and nurses per 100,000 population also have a higher gross domestic product (GDP). For the middle eight and bottom four countries, the numbers of doctors and nurses do not, however, correlate with GDP.

Table 2: Numbers of doctors and nurses vs GDP in sub-Saharan countries

Country	Number of doctors per 100,000	Number of nurses per 100,000	Annual income in US$ (GDP)
Top four countries			
Mauritius	106	369	11 900
South Africa	77	408	10 600
Botswana	40	265	14 100
Namibia	30	306	5 200
Middle eight countries			
Madagascar	29	32	1 000
Zimbabwe	16	72	500
Swaziland	16	630	4 800
Kenya	14	114	1 600
Zambia	12	174	1 400
DRC	11	53	300
Angola	8	115	6 500
Uganda	8	61	1 100
Bottom four countries			
Lesotho	5	62	1 500
Mozambique	3	21	900
Tanzania	2	37	1 100
Malawi	2	59	800

Source: EQUINET SC, 2007

The health care worker crisis in Zimbabwe was taken more seriously a decade ago in 1997, when the President constituted a commission to look into the health sector, including the situation regarding health workers (Commission of Review into the Health Sector, 1999). A motivational survey conducted by Initiatives Inc (1998) on the request of the Zimbabwe government concluded that morale among health workers was very low and mentioned poor salaries, low allowances and poor conditions of service as some of the contributory factors. Musiyambiri (2003) reported that factors like personal influences (perceived personal relevance, accountability and job satisfaction), conditions of service, work environment, macro-economic fundamentals and lack of communication all contributed, in varying degrees, towards the frustration of those CHPs who decided to leave their jobs.

In response to one of the recommendations of the Commission, a Human Resources Committee was established. This committee had various functions, such as advising the Secretary for Health and Child Welfare on annual targets for health worker training and development, reviewing and recommending strategies for the recruitment and retention of health workers to the Secretary every financial quarter, and mobilising sponsorship and support for training and development with the strategic partner community, including the private sector. The committee was also required to assist the Ministry of Health in planning and developing the health services sector in general and to advise the Secretary on what expertise may be required, depending on varying situations and needs.

A key recommendation of the Commission of Review into the Health Sector was the creation of a Health Services Commission that would administer and manage health workers and their affairs. Policy makers, however, opted for the establishment of a Health Service Board that would be a stand-alone institution, running parallel to the Public Service Commission and performing similar functions for health services as the Public Service Commission does for general civil services.

3.1.1 The Zimbabwe Health Service Board (ZHSB)

The ZHSB was created through the Health Services Act no. 28 of 2004 (Chapter 15:16). The vision of the ZHSB is 'to provide an efficient, effective and responsive health services delivery system through a well-motivated, trained and dedicated staff' and its mission is 'to create, promote and develop a conducive working environment for the health services human resources in order to overcome the brain drain from the health sector and provide client satisfaction' (ZHSB, 2006: 2).

In consultation with the Minister of Health and Child Welfare, the ZHSB was mandated to:

- appoint persons to offices, posts and grades in health services;
- create grades in health services and fix conditions of service for its members;
- supervise and monitor health policy planning and public health;
- enquire into, and deal with, complaints made by members of health services;
- supervise, advise and monitor the technical performance of hospital management boards and state-aided hospitals;
- set financial objectives and a framework for hospital management boards and state-aided hospitals;
- handle appeals in relation to disciplinary powers exercised by hospital management boards over members of health services; and
- exercise any other functions that may be imposed or conferred upon the Board in terms of the Health Services Act or any other enactment.

The ZHSB was intended to consist of a full-time executive chairperson, no less than three full-time Board members and no more than two part-time members. Currently there are only two full-time members and one part-time member. In its annual report of 2005, the ZHSB expressed the urgency of appointing a Board member with a legal qualification in terms of Section 5 (2) of the Health Services Act, arguing that their they were losing confidence in all matters with legal implications. The day-to-day activities of the Board are executed by the executive director, with assistance from a director of human resources, conditions of service and public relations, and a director of finances, policy planning and administration. There are currently 14 support staff in position. The ZHSB executes its duties through a number of committees, namely an executive committee, which is chaired by the executive chairperson, a finance and administration committee, which is chaired by a board member, and a human resource committee, which is chaired by a board member. Full board meetings are held, which are chaired by the executive chairperson. The Board operates in close consultation with the Minister of Health and Child Welfare.

3.1.2 What incentives for health worker retention has the ZHSB introduced?

The ZHSB Annual Report (2006) identified the key push factors for the migration of health service workers to other sectors and countries by canvassing Zimbabwe's health workers. The workers said they were motivated to leave by the country's poor economic performance, poverty-level wages, unsupportive management and insufficient social recognition of their work. Their future looks bleak since there are no clear career development strategies in place, especially for new graduates.

In order to manage the problem, ZHSB introduced certain interventions for managing the movement of workers from rural to urban areas when it offered a rural allowance (10% of basic salary) for remote areas, support for the relocation of workers' spouses and suitable accommodation. Rural health facilities were also earmarked for upgrading, and educational allowances and low-interest student loans were offered 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, certain strategies were put in place, such as regular reviews of salaries and

allowances, rewards/incentives for high performers, a reduction in bureaucracy by decentralising responsibilities and authority, and increased budgets for procuring necessary equipment and supplies. The government also undertook to fill vacant posts timeously, embark on management training and correct the errors made in previous job evaluations. It also addressed the problem of workers leaving for other countries by offering study opportunities and low-interest student loans to those who have served in the public sector for more than two years, as well as accommodation and reliable transport, with vehicle purchase schemes for critical members of staff. In the workplace, they will be provided with the necessary equipment, decision-making will be decentralised to enhance efficiency and they may be allowed to cash in remaining leave if they wish to, instead of taking the leave. Furthermore, they may undertake (regulated) private consulting during their normal working days.

Since May 2007, allowances have been paid to employees in line with those payable to members in equivalent grades in the civil service. Staff with medical qualifications, technical or professional, may receive a medical emolument at a rate of 70% of their basic salary, while non-medical staff working within health institutions or in hazardous environments, such as mortuary attendants and ambulance drivers, may receive an H-factor allowance payable at a rate of 20% of their basic salary. Staff who are on call are eligible for an on-call allowance, payable at a rate of 1.35 times their basic salary. Nurses may receive an allowance too when they receive their post-basic qualification (up to a maximum of two qualifications, one of which should be midwifery). The allowance is equivalent to 67.5% of their basic salary, according to the grade for each qualification, but it may not be paid concurrently with an on-call allowance.

The ZHSB has also proposed non-financial incentives to retain health workers, such as developing human resource information systems (HRIS), offering better management, implementing worker loss-abatement strategies and accelerating staff appointments to fill vacant positions. They have also vowed to improve working conditions by, for example, providing better facilities and equipment, better security for workers at the workplace and guaranteeing protective clothing for those who need it. Some of the Board's incentives address social needs, such as the need for housing, staff transport, child-care facilities and assistance in procuring basic food items, for example, by providing a canteen. Training and career path-related incentives have also been proposed for staff embarking on professional development (for example, manpower development leave), as well as research opportunities and opportunities for higher training, like scholarship and bursaries, often in the form of bonding agreements. The Board expressed a need for developing workplace-specific programmes to care for health care workers and their families, and wanted to ensure staff and their family members have access to health care and antiretroviral drugs when they need them.

3.1.3 Successes and challenges of the ZHSB

In the two years since it was established, the ZHSB has made progress in motivating personnel in the health sector in general and CHPs specifically (Health Service Board Annual Reports, 2005, 2006). It concluded the restructuring of the Ministry of Health and Child Welfare to align it with the mandate of the ZHSB. Many staff who had been in an acting position (in some cases, for more than seven years) were substantively appointed, resulting in a motivational boost. The introduction of paid 'development leave' was well received by employees, as they could now develop their skills without suffering loss of income. A consultative process helped the ZHSB to appreciate some causes of health worker attrition, while effective retention incentives were kept and new ones were introduced.

The efforts of the ZHSB during its period of existence have, however, been frustrated by a number of challenges and constraints (Health Service Board Annual Reports, 2005, 2006). A high inflation rate (more than 1,000,000% at the time of the study) has compromised the financial retention incentives that the Board instituted, as the financial gains were rapidly eroded soon after being awarded. The country's negative economic growth has resulted in inadequate staff housing, as the government cannot afford to build more housing to cater for new cadres (World Bank, 2006). Vehicle use entitlements have not been awarded to deserving staffing because of a shortage of funds. Similarly, the vehicle loan scheme became inoperative in 2006. A national shortage of fuel added to transport costs, which eroded the transport allowances awarded to staff without vehicle use benefits. Although the Ministry of Health and Child Welfare has been very supportive, the requirement that the ZHSB closely consults the Ministry has compromised its autonomy.

Table 3 shows statistics on appointments, resignations and retirement of CHPs from January to December 2006. The table also shows a net gain in staff complement, based on the difference between those that resigned and those who were recruited. The statistics indicate that staff lost through resignations were replaced and that staffing levels have improved. The loss of experienced staff is evident. (In this table, the category of paramedics includes medical laboratory scientists, physiotherapists, hospital equipment technicians, pharmacists/pharmacy technicians, dental therapists/technicians, environmental health technicians/officers, radiographers and rehabilitation technicians.)

Table 3: Staff losses and levels at provincial public health institutions, 2006

Staff cadres	New appointments	Resignations	Staff entering retirement	Net staff gained	Net % of staff gained
Provinces					
Doctors	57	17	0	40	70.2
Nurses	1,325	331	12	982	74.1
Paramedics	145	32	1	112	77.2
Total	1,527	380	13	1,134	74.3
Central hospitals					
Doctors	209	33	0	176	84.2
Nurses	1,013	306	23	684	67.5
Paramedics	136	63	0	73	53.7
Total	1,358	402	23	933	68.7

Source: Health Service Board Annual Report, 2006

3.2 Statistics from health professional councils

Table 4 shows the numbers of CHPs who are currently registered with their health professional councils and those who are still registered but have expressed an intention to migrate or have already migrated. The data comes from various health professional councils, which said that the numbers of registered CHPs that they provided are likely to be lower than the actual number of professionals practising in the country, as many CHPs are practising without valid certificates. The numbers of CHPs who expressed interest to register with foreign councils do not reflect those who have actually left the country because some CHPs hold more than one Certificate of Good Standing.

Table 4: Numbers of registered CHPs inside and outside Zimbabwe, 2008

Cadres and institutions	Registered CHPs	CHPs intending to register with councils outside the country (2007)
Medical laboratory and clinical scientists	468	46
Allied health professionals	1,936	88
Rehabilitation practitioners	187	28
Environmental Health Professionals Council	1,000	14
Pharmacists Council	498	10

NB: Medical laboratory and clinical scientists include medical lab technologists, clinical scientists (PhD and Masters), cyto-technicians and specialist clinical blood transfusion technicians. Allied health professionals include paramedics, social workers, health promotion and education officers, medical physicists, natural therapists, nutritionists, psychologists, radiographers and x-ray operators. Rehabilitation practitioners include physiotherapists, occupational therapists, orthopaedic technologists, rehabilitation technicians, speech therapists, chiropodists/podiatrists, orthopaedic technicians and trainee practitioners.

Government-based training institutions have, together with the councils, tried to use the bonding system to retain newly qualified staff in government institutions. Under this arrangement, newly qualified professionals are not issued with certificates until they have completed one or two years of internship in a government institution. This has ensured that the newly qualified staff serve in government institutions for that period but leave soon thereafter. So the sector loses most of its experienced staff, with only those remaining who are serving their bonding period.

3.3 Results of the key informant interviews

In all health institutions visited by the study team the following key informants were interviewed: hospital superintendents, directors of health services, directors of operations, chief medical officers, principal matrons/nursing officers and health service administrators. Key informants had served for an average of 22.3 years in their institutions. *Table* 5 summarises the opinions expressed by key informants from various institutions in response to questions asked by the interviewers.

Government key informants were generally optimistic about the creation of the ZHSB, seeing that their working conditions would improve, with measures to top up salary increments by 20-30%, recognition and pay for postgraduate/basic qualifications, the introduction of a medical allowance and steps to unify the nursing services within public sector. Promotions, especially for those in acting positions, have motivated staff and cases of misconduct were reported to now be dealt with expeditiously.

The lack of clarity on the division of responsibilities between the ZHSB, MoH&CW and PSC was reported to have delayed action in some cases, and while the ZHSB was felt to have potential, its impact on retention was noted to still be limited. Local authority and private sector key informants, in contrast, were not familiar with the operations of the ZHSB, while those in missions noted that it had had a beneficial effect in harmonising the health workers' payroll.

Table 6 summarises the views of key informant interviews regarding the strengths and weaknesses of government policies and strategies to retain CHPs within the country. Interviewees felt that there was no consistent application of the retention policy since the gap in remuneration between employees in private and public institutions was very wide.

Table 5: Views and opinions of key informants on issues critical to attracting and retaining health workers, 2007

Critical issue	Major responses: Financial and non-financial inventives			
	Government institutions	**Local authority**	**Mission hospitals**	**Private for-profit institutions**
Stakeholder familiarity with national policy provisions to retain staff	• Creation of Health Service Board • Retention/medical allowance • Accommodation and transport allowances • Postgraduate training after serving for a number of years • Postgraduate allowance – just introduced	Key informants were familiar with government policies on staff retention and attraction	• Retention allowance • Rural allowance • Housing and transport allowance	No one in private institutions was familiar with government policies on staff retention and related matters
Incentives offered at institutional or responsible authority level	• Supporting staff to attend workshops • Allowing professional freedom, especially for doctors • Subsidised housing, but not enough • Subsidised meals • Flexible working hours • Supporting staff to attend continuing medical education meetings • Giving staff certificates of good standing • Annual prizes for best-performing staff	• Supporting staff to attend workshops • Vehicle loans • Critical area allowances • Education support for children • Housing support	Subsidised housing – but not enough	• Free water and electricity • Social benefits include subsidised medical aid, fully paid school fees for children, a transport allowance (fortnightly in some private institutions), subsidised housing and a Christmas hamper • Good working environment with necessary equipment, drugs and other resources, as well as uniforms and a uniform maintenance allowance • Competitive salary, with annual salary review and bonus • Attractive grading of staff that rewards experience and postgraduate qualifications • Recognition of long service • Flexible working hours
Impact of institutional incentives on staff	Staff not motivated by incentives being offered	Incentives not enough, but staff movement has been stable until recently (2007)	Not much in terms of incentives, but staff movement is relatively stable	To a large extent, staff seem motivated by incentives and staff movement is relatively stable
Staff retention	• Low salaries • Inadequate housing and transport allowances	• Salaries becoming	• Uncompetitive salaries	Heavy workloads are demoralising staff, especially nurses

Critical issue	Major responses: Financial and non-financial inventives			
	Government institutions	**Local authority**	**Mission hospitals**	**Private for-profit institutions**
challenges faced by institutions	• Poor working conditions • Heavy workloads	increasingly uncompetitive • Deteriorating working conditions • Heavy workloads	• Poor working conditions • Inadequate housing support • Heavy workloads	
Staff retention challenges faced by responsible authorities	• Poor remuneration packages fail to attract and retain staff • Poor grading of staff • Resource constraints limiting ability to improve working conditions and remuneration packages • Poor policy implementation, for example inconsistent payout of some allowances	• Increasingly uncompetitive salaries • Inability to provide adequate housing support		Poor grading structures that put health staff as supporting staff to companies' core business
Government bonding policy	• **Positive aspects of policy:** It requires a person trained on taxpayers' money to contribute through service and allows one to get experience working under supervision of experienced staff • **Negative aspects of policy:** Thinking is old-fashioned management – need to change funding of training to cadetship and allow professional freedom by providing conducive working environment and competitive remuneration packages – and it's not a good policy in context of current work environment, characterised by poor working conditions and a resource shortage	Good policy but does not seem to benefit employees or employers in current economic climate, where remuneration packages are too low and working conditions are poor	Good policy, as workers are obliged to pay back for the investment made by government in their training	Good policy, but those bonded should be allowed to work anywhere in Zimbabwe, not just in government institutions

Critical issue	Major responses: Financial and non-financial inventives			
	Government institutions	**Local authority**	**Mission hospitals**	**Private for-profit institutions**
Impact of Zimbabwean Health Service Board on staff retention	• No impact so far but has potential to effect positive changes in the health sector • Appears to have no authority to make decisions on remuneration for health workers • Good idea, but the ZHSB has had limited impact so far and the relationship between ZHSB and Ministry confuses health workers	Do not know much about ZHSB and have not observed any impact of the ZHSB so far	Get same benefits as those in government (were previously disadvantaged) and salaries are now coming in on time	Not familiar with ZHSB, but believe it's a good concept that needs to be supported

Table 6: Opinions of key informants on Zimbabwe's retention incentives, 2007

Incentive	Strengths	Weaknesses
Remuneration	None mentioned by key informants	• Poor overall remuneration package • Packages for professional staff ranks are poorly designed • Poor grading and poor through-grading of staff (postgraduate experience either poorly rewarded or not at all) • Poor pension package – not adjusted for inflation • Under-funded budget • Failure to award professionals for publishing work
Housing support	Schemes for support exist, such as accommodation at some health institutions and a housing allowance	• Inadequate housing units at health institutions • Accommodation allowance too small • Allowances do not contribute to pensionable income
Transport support	• Transport allowance • Vehicle purchase loan scheme	• Value of loans too low to purchase a good vehicle • Loans not easily accessible • Preference given to certain categories of workers
Career advancement	Some structures exist	• Promotions take too long • No transparency in promotions
Continuing education support	• Good training programmes • Opportunities available to all who are eligible	Selection for training sometimes not transparent
Education support for children	None mentioned by key informants	• No support offered by government • Failure to give children of university staff first preference for university entry
Better work conditions, including working hours and leave	No. of leave days is generous	• Poor deployment policy • 40-hour week too long in current strenuous environment • Some allowances discriminate against some categories of workers – for example, general hands/nurse aides who do night duty do not get paid night duty allowance like professional staff
Better work environment, including equipment, facilities, protective clothing, medicines and sundries, space and systems	Infrastructure and operating systems are in place	• Most public health sector facilities poorly resourced – no medicines, linen, sundries or equipment • Inadequate space for patients • Facilities dilapidated, poorly maintained • Equipment old, poorly maintained, obsolete or non-existent
Family relocation support	Support families to be together	No support offered to families regarding relocation costs
Creation of Health Service Board	A separate entity that looks specifically at health workers' conditions of service is a good idea	• Purpose of HSB not well know by majority of workers • HSB poorly marketed, therefore roles of HSB, MoH and PSC are not clear to majority of workers

Government employees sometimes enjoyed organised transport, with some categories of staff eligible for vehicle loan schemes. However, the subsidies received in the private sector were much better, particularly in the case of vehicle loan schemes. It was reported that, despite the country's retention policy, out-migration to neighbouring countries and overseas had increased since the beginning of 2007. Since then, an upward trend in staff resignations has been observed, particularly for nurses. The increased out-migration was attributed to the unfavourable macro-economic environment of the country.

Some key informants expressed concern that policy formulation did not seem to be informed by research, despite the many relevant research studies that have been conducted in the country. They mentioned that a report on vacancy rates and projections of staffing levels was produced some years back but it seemed not to have been used for policy formulation. In their opinion, use of that information could have helped to avoid the current staff shortages.

Others felt that Zimbabwe (and other SADC countries) should emulate the approach of countries like South Africa, which controls the influx of qualified health professionals from other countries. Concern was expressed about the lack of representation of professionals in management at Ministry of Health and Child Welfare Head Office. The current situation is that all top decision-making positions are occupied by doctors, without adequate representation of other categories of health workers.

It was suggested that the structure should be reviewed to reflect the composite nature of health services. They argued that being a doctor did not necessarily make one a good manager. Employing non-medical staff with good management skills and an appreciation of the ministry's core business could result in better health delivery services. An alternative option was to train doctors in positions of management on management issues and include management modules in training of medical professionals.

Some key informants felt that there was need to review the country's disease trends and burden of disease in order to identify the skills required to handle the new challenges. This would help inform the restructuring of training institutions and determine establishment and deployment of health workers for all staff categories.

Informants requested repackaging of remuneration for each category of health workers to adequately recognise their experience and postgraduate qualifications, which would result in competitive remuneration packages being developed for different categories of staff. They also wanted improvements in career advancement pathways, as well as through-grading for staff to reduce the out-migration of CHPs. Currently, when one reaches one's salary 'glass ceiling' (maximium possible salary) one has no motivation left to do better. Furthermore, some staff do not see any chance of attaining senior positions, as all the posts are already occupied by individuals still far from retirement age. Another motivational factor suggested for all health institutions and departments was the recognition of long service by awarding a one off percentage of one's salary on a sliding scale, depending on number of years determined as long service, for example categories could be plus 20 years, 15–20 years, 10–14 years and 5–9 years.

It was suggested that a framework that provides for health institutions to budget for and implement incentive packages at their own levels should be considered. Such a framework would also determine and award allowances for staff working odd hours, such as those on

night duty or on call. Although uniforms are currently provided, respondents felt the uniforms were inadequate and that government should pay for the maintenance of the uniforms. It was suggested that uniform grants should be awarded to new staff and, thereafter, adequate uniform maintenance allowances should be provided.

In view of ever-rising transport costs, respondents suggested that, for certain levels of health facilities, such as general, provincial and central hospitals, a transport system that takes workers from a central place in town to their workplace should be introduced. To assist those qualifying for vehicle loan schemes to purchase vehicles in good condition, it was suggested that the scheme should be adequately resourced. Furthermore, a system that recognises level of responsibility and years of service across categories of professional health workers should be introduced for equitable and transparent access to such loans. Another loan facility suggested was that of assisting workers with school fees. For staff with children studying abroad, assistance in accessing foreign currency at the banks was considered to be a major motivation for staff to stay in the country.

Concern was expressed about the fact that most health workers could not afford decent medical services because of their low salaries and that their medical aid does not meet all their medical expenses. The key informants suggested that the employer should provide adequate medical aid to health workers, their spouses and children. Poor infrastructure in health facilities situated in rural areas was considered to be a serious push factor that needed to be urgently addressed. The basic provisions for such institutions were specified as adequate space in the health facility, housing, electricity, water, transport and communication networks. A quota system that facilitates access to residential land for rural health workers was suggested. Such a system should recognise and include senior health workers (those with long years of service) as priority beneficiaries in the land re-distribution exercise. Although the priority given to the Ministry of Health and Child Welfare during government budgeting was acknowledged, it was felt that more funds had to be allocated to the Ministry.

Respondents suggested the government negotiate with other countries to put in place a system that allows Zimbabwe to benefit from the out-migration of its health workers by charging a levy to the recruiting countries. These negotiations should make sure that the registration criteria for practising in a foreign country are rewritten to be much more stringent.

3.4 Results of the focus group discussions

Five focus group discussions were held with trainee primary care nurses, trainee general nurses (two groups), environmental health technicians and fifth-year medical students. All groups of trainees were in their final year of training and so their views, hopes and fears regarding conditions of service, deployment and their future as health workers were considered key to this study. The views expressed in three of the FGDs are presented in *Table 7* on the following page. They indicate that trainees are motivated by personal commitment, by the character of the profession and by expected benefits in the employment conditions and pay. The expressed preference for working outside the country increased the more high skill the professional. The preferred incentives ranged from welfare and financial incentives for staff and their families, to, at higher skills levels, representation in negotiations and decision making on packages.

Table 7: Views expressed in focus group discussions, 2007

Critical issue (question)	Key responses to critical issues (questions)			
	Trainee primary care nurses	**Trainee general nurses**	**Trainee environmental technician**	**Trainee doctors (fifth year)**
Why did you choose to undertake your training?	• Most were general hands/nurse aides in various health centres,then got the opportunity to get a professional qualification • Desire to help communities by providing professional health services	• Opportunity presented itself • Genuine passion for nursing • Inspiration from someone in the profession • Receipt of salary whilst in training • Training opens doors to seek employment in other countries	• Passion for health sector • Better remuneration • Upgrading from general hand to a more professional career • Flexibility of employment opportunities – mining, health, defence and agricultural sectors	• Prestige associated with profession • Thought it was the highest-paying job • Lacked career guidance • Mistaken belief that earning high marks at school automatically means that one should study medicine
What do you think about the duration of the training period?	Most felt the curriculum was overloaded and congested and the 18 months training period was rather short for such a course. Suggested a period of 2 years	Good	Good	Period is good, as it ensures that a properly trained and knowledgeable graduate comes out of the system
What are your intentions after qualifying?	• Return to serve in their home areas • Upgrade to registered general nurse • Pursue post-graduate training	• Work for three years to complete bonding period and then leave • Become a nurse at Parirenyatwa Hospital • Work for a non-governmental organisation • Contribute towards the improvement of the health sector • Provide a professional service to the nation	• Serve the nation • Seek better employment opportunities in other countries – preferably countries in the same region and particularly South Africa and Botswana • Pursue further studies – (degree and masters)	• Emigrate to other countries • Stay in Zimbabwe, provided salaries and conditions improve • Diversify by engaging in other business ventures that pay well

Critical issue (question)	Key responses to critical issues (questions)			
	Trainee primary care nurses	Trainee general nurses	Trainee environmental technician	Trainee doctors (fifth year)
		• Pursue post-graduate training • Fulfil bonding contract • Get married • Emigrate to other countries for better opportunities		
What are your views on bonding schemes?	• Some students professed ignorance on the issue of bonding – apparently they did not know whether they would be bonded or not • Others knew about and were supportive of the policy	• Bonding schemes are bad because they don't give people a choice • Bonding schemes are good because they ensure that one serves the nation • Bonding schemes are good because they allow one to gain experience • Additional allowances, such as uniform, accommodation, grocery and inflation-adjusted allowances, should be provided as motivation during the bonding period	• It facilitates one to plough back into the country, as the government would have financed studies. • Facilitates novices to gain experiences • Guards against attrition of trained professionals • Students need to be allowed the independence towards choice of employer	• It is a bad policy particularly given that government is not making significant contribution to their training • May have unintended negative impacts as young doctors will not apply themselves fully; they comply just to complete the bonding period • Its intention is good; to maintain a certain number of staffing in the public health sector, but conditions must improve
Which of the policy provisions/ actions that you're getting motivate you?	• Improved salaries • Free medication	• Free training • Subsidised food and rent • Remuneration • Wish list on motivation aspects • Pregnant students must be allowed to complete their courses and free medication must be given to them • Student representatives should be allowed to attend hospital board meetings • Welfare of students should be seriously considered, for example giveleave to allow them to attend funerals and other family gatherings	• Allowances - medical, retention, housing, uniform • Provision of motorcycle •	• As students they felt that government was not making any contribution as their parents paid fees • Majority did not acknowledge existence of packages to retain CHPs, particularly doctors • Those who acknowledged said the package was not viable • Others said it was only promises that were never implemented

Critical issue (question)	Key responses to critical issues (questions)			
	Trainee primary care nurses	**Trainee general nurses**	**Trainee environmental technician**	**Trainee doctors (fifth year)**
What are your intentions to work outside the country as a health professional?	Most had no intention – in the medium term – of going to work outside the country	Most intended to migrate for the following reasons: • Earn foreign currency • Enjoy an improved standards of living • Buy a house and a car • Self-actualisation/self-development • Improved working conditions	Most indicated that, given an opportunity, they would leave and work outside the country	Most said they intended to leave the country for the following reasons: • Better salary • Better working conditions • Vehicle packages • Housing support • Political stability • Career advancement • Comprehensive health insurance
What policies or incentives should be put in place by government to attract and retain staff?	• Accessible car loans at reasonable interest rates • Accessible housing loans • Provision of residential stands • Improvement in accommodation and other living conditions • Improvement in road networks to make some health centres more easily accessible • Improved communication networks, for example by using phones and radios	• Accessible car loans at reasonable interest rates • Provision of accommodation • Subsidised transport and meals • Provision of adequate resources • Improved infrastructure • Educational support for children of staff – the health sector should establish its own school, as is the case for uniformed organisations like the Zimbabwe Republic Police and the Zimbabwe Armed Forces • Provide recreational facilities for staff • Provide free treatment for staff • Government should not publicise salary increments • Allow nurses to take up higher positions in the Ministry	• Provision of motor vehicle • Separation allowance – to be paid every time one is separated from one's family • Loan schemes for purchasing vehicles and houses • Fortnight payment of salaries • Educational support for children • Assistance in accessing basic commodities • Provision of motorcycle (accessing the motorcycles is currently difficult, as allocation/selection criteria are not clear)	• Better salary, benchmarked against other SADC countries • Better working conditions • Vehicle packages • Housing support • Political stability • Career advancement • Comprehensive health insurance • A stable economy • Involve doctors in the dialogue/ negotiating forum as per Statutory Instrument 111 on employment remuneration packages • Motivate professionals while students so that they anticipate being absorbed into the system on completion of their studies • Award scholarships to students on merit and not on political grounds

3.5 Responses to the questionnaires

Seventy-four percent (74%) of respondents from private health institutions said they intended to secure employment outside Zimbabwe, compared to 58%, 51% and 0% from city/urban council institutions, government institutions and faith-based institutions respectively. When disaggregated by level of health institution, the highest percentage of staff with intentions to seek employment outside Zimbabwe was in private hospitals, followed by health centres and central hospitals. Staff at district hospitals expressed the least desire to leave the country (see *Table 8*).

Table 8: Health workers intending to seek employment outside Zimbabwe, 2007

Health institutions	% of staff intending to seek employment outside Zimbabwe
Central hospitals	56
Provincial hospitals	52
District hospitals	35
Health centres/clinics	62
Mission hospitals	57
General hospitals	42
Private hospitals	74

Table 9: Health workers' length of service with current employers, 2007

Staff cadres	Staff numbers	Mean length of service (years)
Junior medical doctors	3	1.7
Senior medical doctors	4	2.7
Dentists/dental therapists	2	11.5
Radiographers	7	5.4
Laboratory scientists/technicians	5	5.6
Registered general nurses (RGNs)	56	5.4
Senior nurses	10	19.8
X-ray operators	1	22
Dispensary assistants	2	12
State certified nurses (SCNs)	2	23.5
Midwives	4	4.5
Operating theatre nurses	1	19
Occupational health nurses	3	10.9
IDSs	1	1
Ophthalmic nurses	1	9
Medical physicists	1	7
Principal orthopaedic technologists	2	26
Junior nurses	30	2.7
Nurses in charge of ward/clinic	33	14.7
Matrons (all grades)	6	23.2
Pharmacists/pharmacy technicians	12	6.6
Physiotherapists/rehabilitation technicians	10	5.6

The desire to seek employment outside Zimbabwe among CHPs varied according to marital status: divorced (83%), single (68%), married (55%), widowed (38%) and separated (1%). The 'stay' factors among different categories of CHPs (what motivated them to stay in service) were assessed by asking staff how long they had been employed by their current employer. The results are summarised in *Table 9*.

Senior staff had stayed with their current employers for longer periods than junior staff. An assessment of how long various responsible authorities retained their staff was done by cross-tabulating how long employees had worked for the authorities (see *Table 10*). A total of 181 staff were sampled, most of which had stayed with their employers for 10 years or less. The Ministry of Health and Child Welfare and the city councils had the longest-serving members.

Table 10: Health workers' length of service at various health institutions, 2007

Length of service (years)	% of respondents in the provider type (*)			
	Ministry of Health	City councils	Faith-based mission facilities	Private facilities
1–5	53	42	100	61
6–10	18	25	0	11
11–15	7	0	0	9
16–20	7	17	0	9
21–25	8	8	0	7
26+	7	8	0	2

Any differences to a total of 100% are due to rounding of percentages

Table 11 shows the preferred destinations of interviewed health workers who are considering emigrating.

Table 11: Preferred destinations of health workers considering emigrating, 2007

Preferred destination	Frequency of responses by interviewees	% of total responses
South Africa	72	26.0
Australia	47	17.0
Botswana	46	16.0
United Kingdom	36	13.0
Namibia	26	9.0
New Zealand	23	8.0
United States of America	10	4.0
Swaziland	8	3.0
Canada	7	2.0
Asia	3	1.0
Mozambique	1	0.4
Netherlands	1	0.4
Ireland	1	0.4
Saudi Arabia	1	0.4
Total	**282**	**[100]**

Within the SADC region, South Africa was most often mentioned as the country most preferred by staff intending to emigrate, followed by Botswana and Namibia. The preferred high income country destination was Australia, followed by the United Kingdom and New Zealand. The choice of destination was largely determined by the extent to which recruiting agencies/ countries facilitate relocation, such as visa and work permit applications and spouse relocation opportunities.

The reasons for wishing to leave current jobs are shown in *Table 12*. Pursuit of better remuneration (26%) and desire to join a spouse (which implies many people already have spouses outside the country) (24%) were the most popular reasons. Other common reasons included improved work environments, career advancement and child education.

Table 12: Why health workers are considering leaving their jobs, 2007

Reason	Frequency of responses by interviewees	% of total responses
Better career advancement opportunities	39	8
To join family	115	24
Retrenchment	7	1
End of contract	15	3
Good working hours	1	0
Security	21	4
Promotion	7	1
Patriotism	7	1
Better postgraduate training opportunities	9	2
Better housing supporting	18	4
Better education support for children	24	5
Better working environment	42	9
Better remuneration	128	26
Different job altogether	21	4
Open vacancy	14	3
Transfer	21	4
Total	**489**	**[100]**

Table 13: Incentives that health workers believe will help to retain staff, 2007

Suggested incentives	Frequency of responses by interviewees	% of total responses
Inflation-adjusted salaries	159	31.8
Housing schemes and loans	131	26.2
Transport – car purchase assistance	111	22.2
Educational support for children	50	10
Better working conditions	61	12.2
Basic resources and sanitary ware	26	5.2
Post-basic training	16	3.2
Medical allowance	15	3
Making basic commodities available	13	2.6
Transport – staff bus	13	2.6
Gratuities and recognition for good work	12	2.4
Medical aid for the health worker's family	11	2.2
Total	**500**	**[100]**

Table 13 lists the incentives that health workers believed would help to retain staff. Inflation-adjusted salaries were the most commonly mentioned incentive (31.8%), followed by housing schemes and loans (26.2%), vehicle purchase schemes (22.2%) and financial support for the education of the respondent's children (10%).

3.6 Views expressed during the stakeholder workshop

As outlined in the methods, a workshop involving stakeholders was held to present the initial findings and elicit feedback that would be integrated into the report.

The discussion provided useful insight on the performance of the incentives in practice. While allowances were considered to be potentially a good incentive, the principle of basing all allowances on an employee's basic salary was viewed as a major weakness, as respondents felt that their salaries were too low. Other challenges emerged in the award of allowances. Some junior doctors were reported to earn more than consultants, in real terms. This anomaly, caused by on-call allowances, has had a de-motivating effect on senior professionals, particularly those engaged in teaching. It was also felt that loan schemes were not easily accessible to beneficiaries. Workshop participants wanted the current practice of forfeiting leave days accrued beyond a certain threshold to be reviewed, as most staff could not take leave owing to them because of staff shortages. Although mechanisms for making basic commodities accessible to staff were in place, there was need to institute a control system that would bring more equity.

Bonding was considered to be counter-productive, as serious would-be emigrants did not feel they lost anything by absconding. Development of a clearly defined career path and opportunities for continuing education were considered to be better 'bonding' strategies, which, while not legally binding, were already more effective in retaining staff. The current situation for some senior positions was described as a 'glass ceiling' beyond which career progression seems impossible. Another major weakness reported in the retention scheme was its exclusion of CHPs in higher education. Lecturers in the medical school and their management are considered to be part of the tertiary education ministry and therefore do not benefit from packages given by the ZHSB. The result is that graduating students may, after a short while, earn more than their mentors. The ZHSB has engaged the Ministry of Tertiary Education on this aspect without success.

Despite the weaknesses described above, it was acknowledged that health workers were currently the highest paid civil servants in Zimbabwe and that a career path for most staff categories had been clearly defined. The adjustment of the retirement age had also eased pressure on existing staff, as professionals could remain in service for additional years.

Exemption or reducing duty on imported motor vehicles for health professionals was suggested as a way of improving access to motor vehicles by staff. Creating a forum for coordinating issues related to health workers was considered to be an important incentive, as it would give health professionals a sense of ownership in the development of incentives packages. Participants felt that there had to be more emphasis on non-financial incentives, as they impacted on the wellbeing of the employee's family. Nevertheless, it was felt that matching real salaries to those prevailing in the SADC region would be a great incentive.

Most stakeholders felt that to strengthening the ZHSB it was necessary to make it truly autonomous. This requires a re-examination of the *Health Services Act no. 28 of 2004* (Chapter 15:16), which created the ZHSB. Currently the Board consults the Minister of

Health and Child Welfare, who ratifies all decisions. Other points raised included increasing funding levels for the ZHSB, filling vacant posts at board level, particularly those of board members with a legal background, and streamlining the roles of the Ministry and the Board.

Advocacy for government-to-government negotiations on the recruitment of health workers from another country was recommended as a way of ensuring that governments facilitated movement of staff in a cost-effective way. The introduction of levies payable to the country of origin for every CHP recruited was suggested. Such a levy should not affect the remuneration package of the recruited staff. Another suggestion was to put in place mechanisms for those in the diaspora (health workers who have already left), particularly those within the SADC region, to return home and provide services under a kind of sabbatical arrangement. For such arrangements to be effective, government would have to provide competitive packages to entice staff back.

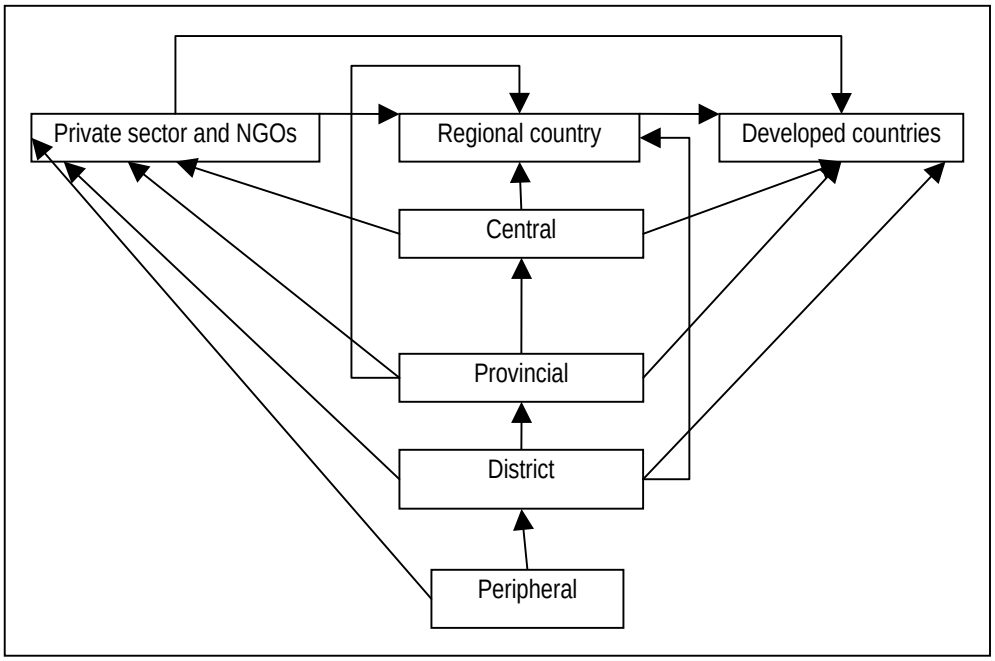
4. Discussion

4.1 Out-migration of critical health professionals

Results from this study show that Zimbabwe is losing its most experienced CHPs, and remaining staff are mostly newly qualified staff who wish to gain experience and/or have to fulfil bonding contractual arrangements. However, staff in positions of authority and others who have ventured into some form of business, related (private practice) or unrelated (such as farming, transport or construction) to their professional jobs, seem to stay longer in their jobs, as they supplement their salaries with proceeds from such businesses. The CHPs who have ventured into business seem to be role models for students, as some medical students indicated that their intention was to diversify and not necessarily focus on practising as doctors. Unfortunately, this diversification only serves to divide a practitioner's attention, negatively impacting on the health delivery system. There were more CHPs in private health institutions who expressed the desire to leave their employment than staff from other institutions. This is probably because no other institution within the country would be able to match their current remuneration packages. A point of concern was the fact that many more staff at lower levels of the public health system expressed the intention to leave the country. In the past, staff at peripheral levels wished to relocate to provinces or central institutions before they considered leaving the country. The model observed in this study (*Figure 4*) is similar to the one reported by Pillay (2007). Pillay’s model showed that staff move from both the primary and secondary levels to higher levels within the country or to other countries.

Another worrying phenomenon was the intention to migrate expressed by trainee doctors and nurses, which ruins any hopes of replacing migrating CHPs with newly trained cadres. Students felt neglected, as there was no motivation for them to aspire to be assimilated in the country’s health delivery system. This suggests that the current system targets qualified staff while paying little attention to potential recruits.

Figure 4: Health worker migration trends in Zimbabwe, 2008



The biggest push factors for staff leaving the country are uneconomical remuneration packages and the desire to reunite with the family in cases where a spouse is already in the diaspora. Among CHPs who expressed the intention to leave the country, the most mobile CHPs were those who were single and divorced, probably because they have less restrictive family commitments than married people. Zimbabwe is not the only country experiencing a migration outflow of CHPs. Country presentations made at the First Global Forum on Human Resources for Health held in Kampala, Uganda (GHWA, 2008), highlighted similar problems for Zambia, Swaziland, Burkina Faso, Sierra Leone and Lebanon. Reasons for migration are generally common across African countries but the Zimbabwean situation is exacerbated by the current economic conditions, with inflation exceeding 1,000,000% in 2008.

4.2 Staff retention strategies

Through the Zimbabwe Health Service Board, the government of Zimbabwe has introduced and is implementing a retention package for health professionals in government institutions. The package includes both financial and non-financial incentives. However, financial incentives are failing to achieve the desired results (retaining health professional staff) because of the hyper-inflationary environment in the country. Results from the field survey (questionnaires, interviews and FGDs) indicated that some staff were not aware of some financial incentives like the H-factor in their salary and the urge that health professionals have over other civil servants. This was probably because the incentives did not improve their disposable income. Furthermore, there were disgruntlements expressed with regard to some allowances like night duty allowance allocated to doctors and nurses but not to other staff working overnight alongside CHPs. This usually compromises the quality of the service provided. It was noted that the proposed incentives packages to minimise rural to urban migration is rather general, as it includes other incentives also applicable to all health workers, for example, low interest loans and educational allowances.

Non-financial incentives were greatly appreciated by CHPs, such as confirmation of staff that had acted in senior positions over many years, professional advancement leave and recognition of higher qualifications in the case of nursing staff. Among the non-financial incentives, vehicle and accommodation loan schemes were most appreciated but unfortunately that component of the incentives package was not yet fully operational because of funding constraints. Data collected using various methods applied in the study indicated that improvement of the working environment and assistance for child education, accommodation and transport were key desired incentives.

Documents available at the ZHSB showed that proposals to include these aspects had been submitted to government and the Board was hopeful that the package would be approved. It should, however, be noted that some of the high impact interventions cannot be unilaterally implemented by the ZHSB, as the mandate may be in another Ministry. For example, improving access to rural health facilities would be an incentive for health workers but roads and bus services go beyond the mandate of the ZHSB. Similarly, improving infrastructure is a ministerial (MoH and CW) mandate and, in some cases, a mandate of the Ministry of Local Government, Public Works and Urban Development or the Ministry of Rural Housing and Social Amenities. This obviously limits the capacity of ZHSB to implement a complete retention package.

Private and municipal health institutions seemed to have much better retention packages than public (government) health institutions, which is apparent from the greater number of years that staff in private health institutions had remained in employment compared to their counterparts in government health institutions. Municipal institutions seemed to retain their health professionals longer than both government and private health institutions (*Table 10*). The observation that the private sector is more attractive to CHPs is contrary to the situation in Botswana, where CHPs in public health institutions earn better salaries than their counterparts in some private health institutions (personal communication with private and public doctors in Maun, Botswana).

The concept of bonding as a means of retaining staff was considered to be an infringement on the rights of individuals by some staff. However, others, particularly those under training (excluding trainee doctors), saw it as a way of gaining experience and paying back to the state for educational support received. It was, however, made clear that bonding was not a deterrent to out migration because individuals were prepared to forfeit their terminal benefits. Bonding staff in a hyper-inflationary environment is not effective, as the penalty for defaulting bonding agreement is often surpassed by offers for prospective jobs. Stakeholders felt that career path incentives were more effective than bonding. The Zimbabwe Health Service Board expressed the same sentiments, preferring motivational incentives (HSB annual report, 2005).

4.3 Implementation of retention strategies

The strategies for retaining HP are being implemented through the ZHSB. The Zimbabwe Health Service Board was established to specifically focus on health workers so that their concerns could be dealt with with less bureaucracy than the Public Service Commission, which is the sole employer of all civil servants. The 2005–2010 Strategic Plan for the ZHSB provides a framework within which the retention incentives package can be implemented. The Key Result Area (KRA) 6 specifically aims to improve conditions of service for health services, while the other KRAs seek to establish a policy framework to

support the welfare of health workers as indicated in objective 7: 'to improve the health and general welfare of staff'. The ZHSB annual reports of 2005 and 2006 indicate that implementation of the strategic plan is on course. The Board has engaged its stakeholders at different levels. Despite the consultations that ZHSB claim they did, many health workers at district levels seemed unaware of such consultations and the efforts being made by the Board.

In comparison to the ZHSB, private and municipality health institutions seemed not to give health staff special treatment, as they were graded along the same lines as the rest of the employees in the organisation. In this regard, the introduction of the ZHSB may in the long run make government health institutions more attractive to CHPs than private and municipal health institutions because the Board will have made it possible to give preferential treatment to health workers.

4.4 Monitoring and assessment of the impact of retention strategies

There was no evidence of deliberate monitoring and impact assessment strategies for the retention of CHPs in all responsible authorities we studied, except government. Perhaps this is because loss of staff has not been as much of a challenge to these institutions as it has been in government. There seems to be a continuous movement of staff from public institutions to fill the gaps left by staff vacating private health institutions. In government there was evidence of a clear monitoring strategy for retention of staff. KRA 4 of the ZHSB ('to improve the availability of information on human resources for health [HRH] by December, 2008') is clear testimony of the Board's commitment to monitor strategies to retain CHPs and health workers in general. In its objectives, objective 2 has as one of its outputs medical brain drain statistics and objective 3 specifies the output of a computerised HR database.

Discussions with board members of the ZHSB indicated that an impact assessment was planned but the monitoring process would be continuous. The situation on the ground and data on current establishments obtained in accordance with the KRA, however, suggest that little or no impact has been made on the retention of CHPs in health institutions of all the responsible authorities we studied.

4.5 Sustainability of retention strategies

All the responsible authorities we studied are struggling to introduce attractive retention incentives for their CHPs. The efforts that have been made are not being sustained in the short term because of the hyper-inflationary environment prevailing in the country, which we referred to earlier. Under these conditions, it appears that non-financial incentives may be more sustainable than financial incentives. The ZHSB states in its strategic plan its intention to reduce vacancy levels of CHPs from 55% (2006) to 10% (2010) by approving the appointment of suitable employees who have been in acting capacities for a minimum of six months and prompt advertising and filling of posts. These actions motivate staff and help to retain them. During FGDs, some staff suggested that government give preference to CHPs in rural settings during land allocation. This was well received by members of the ZHSB. This strategy could be useful, however, as it has some 'stick' value (encourages workers to stay). Some of the senior CHPs who were established in remote areas were reluctant to move away, as they had investments to safeguard in these areas. One major challenge in trying to develop and sustain retention packages is how to justify such packages for CHPs when government has many critical professionals in other ministries.

So, government cannot wholly provide funding for such packages, as other ministries would demand the same allocations. Partnerships with industry, NGOs and communities that are served by CHPs seem to be the way forward.

4.6 Final issues and areas of follow up research

Some unexpected issues came up during the research process. For example, the issue of management was brought up in discussions with non-medical staff. Staff from most non-medical cadres in the health sector felt that there was a need for a professional mix in the mainstream of the Ministry of Health and Child Welfare. Currently, only medical doctors can become permanent secretaries for the Ministry and most key positions are occupied by doctors. The argument was that doctors are not necessarily good managers. Some doctors admitted that doctors were not necessarily good managers and suggested that management courses be included in curricular for medical students, but were opposed to the idea of having a non-medical leadership. This issue remained unresolved, as was the case at the First Global Forum for Human Resources for Health (2008), where it was extensively discussed with vivid examples of good managers with only a nursing background working in countries like South Africa and Swaziland.
Although the ZHSB indicated in one of their reports that they had finalised the restructuring of the Ministry of Health and Child Welfare to align it more closely to the ZHSB, some study participants said the relationship between the Ministry and the ZHSB was not clear and needed to be clarified. In the same discussions in which this issue was raised, the need for ZHSB to be more autonomous in its decision making was highlighted. The issue of reporting lines was also highlighted. The Permanent Secretary for the Ministry of Health and Child Welfare is not accountable to the ZHSB, making it difficult for ZHSB to influence his operations, if there is difference of opinion.

The study would have benefited from data that documents the actual numbers of CHPs that have left the country but it was difficult to obtain, as people are not obliged to indicate where they intend to go upon resigning. As a result, we had to rely on *expressed interest* to emigrate. Perhaps such information on out-migration destinations could be obtained by collaborating with recruiting countries, which could indicate the number of CHPs they recruited at any given time. This suggestion is beyond the scope of the present study, but may be worth pursuing.

During the study, we observed that many CHPs have diversified their livelihoods activities to include activities unrelated to their profession. Medical students who participated in focus group discussions indicated that they too hoped to diversify, once they qualified as doctors. This has implications for the services provided, with cadres having divided attention. It is important to assess the impact of diversification of activities by CHPs on their performance of the core business, as follow up research to this project.

Other issues were reaised as constraints limiting effectiveness of health workers. During a feedback discussion with members of the ZHSB concern was raised, for example, over utilization and servicing of health care equipment. A suggestion was made to assess the extent to which equipment bought in Zimbabwe since independence had been utilized, and examine constraints faced with regards to maintenance of such equipment.

During the feedback workshop it was also raised that there may be need to be a review of the operations of the ZHSB and its relationship with the Ministry of Health and Child Welfare. These aspects were beyond the scope of the current project. Such a study could

be in the form of an evaluation of the ZHSB, aimed at assessing its impacts since it's formation. This could address issues relating to staffing allocations between central and lower levels, given the roles taken on by the ZHSB, and the relative allocation of staff between Ministry and ZHSB in relation to the responsibilities of each institution.

5. Conclusion and recommendations

The out-migration of CHPs to countries in the region or overseas is one of Zimbabwe's most pressing problems. The movement of staff is no longer only from lower to higher levels of the public sector or from public to private institutions within the country, or of high skills personnel outside the country. Now even low-level staff are leaving for other countries in and beyond the region.

The major factor driving out-migration was found to be the economic hardship that the CHPs are facing due to the deterioration of the country's economy. Other factors identified, including poor remuneration, unattractive financial incentives and poor working conditions, relate directly to this. Strategies to retain CHPs have been put in place and non-financial incentives introduced or proposed, that are appreciated by the beneficiaries. The ZHSB strategic plan for 2005–2010 provides a good framework for monitoring and evaluating the incentives programme. However, the impact of these strategies are undermined by economic conditions such as hyper-inflation.

The concept of bonding staff as a means of retaining them is unpopular and tends to promote desertion of staff without giving the contractual notice period. While the concept itself is not resented, it is currently viewed as being punitive as it forces one to live on an unsustainable remuneration package while serving the bonding period. The selective awarding of allowances to health workers has a demoralising effect on those that do not receive the allowances, particularly in circumstances where the working hours and conditions are similar. The exclusion of CHPs in the Ministry of Higher and Tertiary Education from the mandate of the ZHSB has created serious disparities in remuneration between staff in the ministry and those under the ZHSB. Doctors and trainee general nurses generally do not look forward to working in the country after completing their studies because of what they consider to be serious suffering by those already employed. While on paper the retention package for Zimbabwe is very appealing, there is need to make it effective by fully implementing what is documented as intentions, or what is being done less efficiently because of constraints that the country is experiencing.

We have a number of recommendations to make. We believe that retention strategies should target all staff categories, as there is a tendency for staff at all levels to migrate. The strategy should be extended to training institutions so as to encourage trainees to join the country's health sector upon completion of their studies. In the current hyperinflationary environment, emphasis must be put on non-financial incentives that are not directly eroded by inflation. The concept of bonding staff as a means of retaining them should be revisited so that it does not appear to be a punitive measure. An incentive package that allows young professionals to pay for basic needs, for example to buy a TV, a radio, furniture and a car, should be considered as a way of making them enjoy their bonding period. Equally career path incentives were raised as preferable to bonding.

Awarding of allowances should be rationalised so that staff working under similar conditions get the same allowances on a sliding scale based on their grades, rather than awarding certain categories of staff only. Remuneration of CHPs in the Ministry of Higher

and Tertiary Education and those under the ZHSB should be harmonised. Efforts to improve the professional mix in the hierarchy of the Ministry of Health and Child Welfare should be made. Modules on management should be included in the training curriculum of health professionals. CHPs already in management positions but lacking in management skills should be sent for training in management.

We suggest that managing health worker incentives calls for the ZHSB to have greater decision making latitude. While oversight of some decisions is needed, there is scope for giving the ZHSB greater authority for decision making on incentives. This would need to be further explored and may involve revisiting the *Health Services Act no. 28 of 2004* (Chapter 15:16) to address issues of accountability and powers in relation to the ZHSB.

There is further a need to improve the evidence for planning. The ZHSB should be able to document the actual number of CHPs leaving the country and the countries they go to. This calls for multi-country arrangements that will facilitate exchange of information on the registration of foreign CHPs in participating countries. The World Health Assembly Code that is being developed may help address this problem, but will need to go beyond the code to address the problems in operationalising such arrangements, including strengthening the databases at country level to support this information exchange.

References

1. African Union (2005) *African Union Health Minister's Decisions on Human Resources, 2005*. African Union: Addis Ababa, Ethiopia.
2. Chikanda A (2004) 'Skilled health professionals' migration and its impact on health delivery in Zimbabwe', *Working paper* 4. Centre on Migration, Policy and Society, Oxford University: Oxford.
3. Commission of Review into the Health Sector (1999) *Republic of Zimbabwe Report for the President of Zimbabwe*. Government of Zimbabwe: Harare.
4. Dambisya Y (2007) 'Review of the literature on incentives for retention of health workers in east and southern Africa: Methods used, issues arising', paper presented at *EQUINET workshop on health worker retention and migration in east and southern Africa, 17–19 March, Arusha, Tanzania*. EQUINET: Harare.
5. Eastwood JB, Conroy RE, Naicker S, West PA, Tutt RC and Plange-Rhule J (2005) 'Loss of health professional from sub-Saharan Africa: The pivotal role of the UK', The Lancet 365(1893) 1900.
6. EQUINET SC (2007) *Reclaiming the Resources for Health: A Regional Analysis of Equity in Health in East and Southern Africa*. EQUINET: Weaver press, Fountain Publishers and Jacana Media: Harare, Uganda and Johannesburg.
7. Global Health Workforce Alliance (2008) *First Global Forum on Human Resources for Health, Uganda, Kampala, 2–7 March*. Global Health Workforce Alliance: Switzerland.
8. Ministry of Health and Child Welfare (2004) *Health Services Act No. 28 of 2004*. Government of Zimbabwe: Harare.
9. Health Service Board (2005) *Pulling Together for Health: Annual Report, 2005*. Health Service Board: Harare.
10. Health Service Board (2006) *Pulling Together for Health: Annual Report, 2006*. Health Service Board: Harare.
11. Initiatives Inc. (1998) *Ministry of Health and Child Welfare Report of the Motivational Survey: Volume 1*. Initiatives Inc.: Boston.
12. Lancet editorial (2005) 'Migration of health workers: An unmanaged crisis', *The Lancet* 365.
13. Lancet editorial (2008) 'Finding solutions to the human resources for health crisis', *The Lancet* 371:623.
14. McIntosh T, Torgerson R and Klassen N (2007) *The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada*. Canada Policy Research Networks: Ontario.
15. Musiyambiri M (2003) An Evaluation of the Performance Appraisal System of the Ministry of Health and Child Welfare. Zimbabwe Public Administration Management Institute: Harare.
16. Mutiswa MD and Mbengwe AG (2000) 'Human resource policies and equity in health in southern Africa', paper presented at *EQUINET conference, Midrand, September 2000*. EQUINET: Harare.
17. New Partnership for Africa's Development (2001) *Abuja Declaration, 2001*. NEPAD: Nairobi.
18. Pillay R (2007) 'A framework for the strategic analysis and management of the brain drain of African health care professionals: An innovation systems approach', *Special Paper* 32. African Technology Policy Studies Network (ATPS): Nairobi.

19. Robinson M and Clark P (2008) 'Forging solutions to health worker migration', *The Lancet* 371(9613):691–693.

20. SADC-HRH (2006) *Southern Africa Development Community Human Resources for Health Strategic Plan, 2006–2019*. SADC: Johannesburg.

21. World Health Organisation (2005) *Make Every Mother and Child Count: World Health Report*. WHO: Geneva.

22. World Health Assembly (2006) *Fifty-ninth World Health Assembly, May*. World Health Assembly: Geneva.

23. World Health Organisation (2006) *Working Together for Health: World Health Report*. Geneva: World Health Organisation.

24. World Health Organisation (2007) *WHO Global Health Atlas Database*. WHO: Geveva, available at http://www.who.int/globalatlas.

25. Zimbabwe Health Service Board (2005) *Health Service Board Annual Report: June–December 2005*. Zimbabwe Health Service Board: Harare.

26. Zimbabwe Health Service Board (2005) *Health Service Board Strategic Plan: 2005–2010*. Zimbabwe Health Service Board: Harare.

27. Zimbabwe Health Service Board (2006) *Health Service Board Annual Report*. Zimbabwe Health Service Board: Harare.

Acknowledgements

We are grateful to the Regional Network for Equity in Health in east and southern Africa (EQUINET) for funding and technically supporting and mentoring this research and to the Zimbabwe Ministry of Health and Child Welfare for permission to conduct the research. The Director of Human Resources in the Ministry of Health and Child Welfare was very cooperative in this regard. We are also thankful to all study participants who allowed us to interview them and gave us the information we requested for. Mrs R Chekera collected additional data in accordance with the recommendations by participants of the stakeholder dissemination workshop. Last but not least we would like to thank Mrs Mabvira for logistical support during implementation of the project and Mrs F. Chimbari for proof reading the report.

Acronyms

UK	United Kingdom
USA	United States of America
WHO	World Health Organisation
WHA	World Health Assembly
SADC-HRH	Southern Africa Development Community Human Resources for Health
ECSA	East, central and southern Africa
ZHSB	Zimbabwe Health Service Board
HPs	Health professionals
MoH&CW	Ministry of Health and Child Welfare
CHPs	Critical health professionals
CSO	Central Statistical Office
FGD	Focus group discussion
PCN	Primary care nurses
EHT	Environmental health technicians
TOR	Terms of reference
HRIS	Human resource information systems

PSC	Public Service Commission
KRAs	Key result area

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue Editor: S Iipinge, Y Dambisya, H Lugina, P Norden, R Pointer, R Loewenson