

Distribution of public sector health workers in Zimbabwe: A challenge for equity in health

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Executive summary

Zimbabwe, like many other countries in the region, is badly affected by a shortage of health workers. Many of the health indicator improvements achieved during the first ten years of independence are on the decline and the main reason for this is shortage of skilled and experienced health workers at a time when demand for services is increasing due to a growing population and the challenges posed by HIV/AIDS. The public sector provides as much as 65% of health care services in the country (MoHCW 2004), and so a shortage of public sector health workers affects a great majority of the population.

Against this background of increasing shortages, concern has been expressed about giving prominence to improved management and better distribution of human resource in health care systems within the SADC region, an area that is witnessing deteriorating health indicators due to shortage of health professionals. This study explored the distribution of public sector health workers to show how its pattern impacts on equity objectives in health care delivery. The research was carried out in the context of the EQUINET theme work on *Human Resources for Health* and AIDS and health systems, supported by SIDA Sweden and IDRC Canada.

A wide range of official policy documents, statistical information and other literature was reviewed and analysed, and consultations and discussions with key officials held.

The results summarized in this paper show the different dimensions of equity impacted by the distribution of public sector health workers in Zimbabwe. Key issues emerging from the analysis point to:

- (i) the long fruition time for many initiatives taken to improve the maldistribution of health workers;
- (ii) the importance of involving other sectors and not just the MoHCW in formulating deployment and distribution policies for health workers; and
- (iii) the policy gaps between the MoHCW and the PSC in matters of planning for increased numbers and distribution of health workers.

Given the complexity of factors influencing the availability of health workers in public sectors in general, the Zimbabwe Health Services Board would greatly benefit from experiences of other countries that have had operational Boards over the years. Ghana and Zambia have had operational health boards to provide comparative experiences from which Zimbabwe could benefit. Other regional bodies like EQUINET provide opportunities to share information on the dimensions of human resources in achieving equity in health care and services provision. Ultimately, investment in human resources is the largest component of all health budgets, a fact that demonstrates its critical contribution to improved health for the poor and disadvantaged.

1. Introduction

The *World Health Report 2000* (WHO 2000) argued that health human resources are key determinants of the success or failure of health systems. The performance of health care systems is a function of the availability, know-how, skills mix and motivation of personnel delivering services.

Zimbabwe, like many other countries in the region, is badly affected by a shortage of health workers. Many of the health indicator improvements achieved during the first ten years of independence are on the decline and the main reason for this is shortage of skilled and experienced health workers at a time when demand for services is increasing due to a growing population and the challenges posed by HIV/AIDS. The public sector provides as much as 65% of health care services in the country (MoHCW 2004), and so a shortage of public sector health workers affects a great majority of the population.

Health professional groups with the highest loss rate in Zimbabwe are doctors, nurses and pharmacists. Current figures showing vacancies are likely to be underestimates because often the official records do not reconcile with figures obtained through actual visits to health facilities. Although other non-clinical health workers make a significant contribution, it is the shortage of these key clinical professionals that limit accessibility to health care for the majority of patients, especially those that are economically-disadvantaged and located in geographically-deprived areas. Since 1999, increased numbers of skilled health workers have migrated to regional and international destinations. In 2004, the MoHCW published figures that showed that 2,825 work permits were processed for Zimbabwean health professionals to enter the United Kingdom. The figure represents about 25% of the professional health workforce in the Zimbabwean public sector.

Attrition of health workers in the public sector is due to factors that mainly relate to lack of incentives, poor salaries and conditions of services (Paulinus et al 2000). HIV/AIDS has not spared health workers either. Especially for the public sector, more health workers are lost than the training institutions are able to replenish, implying potential inequities in services provision. It should also be noted that the private health sector suffers from the same problem.

The different strategies employed to retain staff in the public sector have had mixed impact on distribution of health workers, mainly because of a lack of complementary policies between the other public sector departments and the Ministry of Health and Child Welfare (MoHCW). In practice, the Public Service Commission (PSC), not the MoHCW, is the ultimate employer of all health workers as civil servants. The majority of human resource policies that impact on the distribution of health workers are therefore managed and controlled by the PSC with the MoHCW relegated to overseeing implementation and monitoring of technical policies for health care delivery. This position prevailed up to July 2005 when the Health Service Board (HSB) was put in place to play the role of the PSC.

The Equity in Health (MoH, 1980) action plan conceived policies for an expansion moratorium on urban health facilities and shifting of human resources to previously understaffed rural areas as its major thrust. *Table 3* data however suggest that rural posts still lag behind urban establishment despite policies for redressing the imbalance.

It is against this background of increasing shortages that concern has been expressed about giving prominence to improved management and better distribution of human resource in health care systems within the SADC region, an area that is witnessing deteriorating health indicators due to shortage of health professionals (EQUINET, HST 2005). This study explored the distribution of public sector health workers to show how its pattern impacts on equity objectives in health care delivery.

The specific objectives were four-pronged:

- (i) establish distribution of health workers in public and private sectors;
- (ii) establish the rural and urban distribution of public sector health workers in terms of posts established by the government and the deployment of the different professional categories;
- (iii) identify equity-impacting policy gaps in the distribution of health workers as implemented and managed by the public sector represented by the PSC and MoHCW; and
- (iv) make recommendations for improvements in the public sector distribution of human resources with the aim of improving service delivery for those parts of the population with the greatest health needs.

2. Methods

From the reviewed literature, we noted the definition of equity as very situational, but all definitions were concerned with “fairness” – such as equal availability or use of health services in relation to the need for them by patients. Our approach therefore considered the distribution of health human resources as one very important measure of fairness in health services provision. We took the distribution of health human resources as not merely the availability of numbers but rather the geographical location (rural vs. urban), skills mix, professionals mix and numbers of approved post for the different categories of professionals needed at different levels of health facilities. We assumed that for their education and disposable income, the affluent tend to consume a larger proportion of health resources than the poor who probably have higher needs.

A wide range of official policy documents, statistical information and other literature was reviewed and analyzed. Our methodology also involved consultations and discussions with key officials at the PSC, MoHCW and key health stakeholders represented by Zimbabwe Medical Association (ZiMA), Zimbabwe Nurses Association (ZINA), Zimbabwe Association of Church related Hospitals (ZACH) and National Association of Medical Aid Societies (NAMAS). The literature reviewed included minutes of relevant meetings held in the past and up to the period of the study – November 2004.

3. Results

The study highlights a number of policy issues impacting on the equitable distribution of professional and skilled or experienced health workers by especially rural and peri-urban consumers presenting at public sector facilities. Maldistribution occurs mainly because of the inability of the MoHCW to influence the PSC to respond in a timely fashion to increased demands not only for more health workers but also for retaining experienced personnel at public sector facilities, especially in rural and other geographically-disadvantaged areas. We summarize the major findings for:

- (i) contributions of the public and private sectors in advancing health equity;

- (ii) the geographical and professional distribution of established posts for health workers in the public sector; and
- (iii) policy gaps between the PSC and MoHCW in creating a pro-equity distribution of health workers in the public sector and enabling the retention of health workers at public sector facilities.

3.1. Contributions of the public and private sectors

3.1.1. The public sector

The public sector remains the largest contributor towards human resources for health. Sixty-five percent (65%) of national health workers (21,265 health posts) are employed by the public sector through the PSC. Seventy percent (70%) of the national stock of health facilities is owned, financed and managed by the public sector (MoHCW 2004). The largest proportion of public sector expenditure on health (average 40%) goes to finance salaries and allowances (Ministry of Finance and Economic Planning, 2004). *Table 1* figures are not adjusted for inflation but still illustrate the public sector contribution in financial terms, showing human resources' share of public expenditure on health in the years 1999 to 2004.

Table 1: Human Resources share of public health expenditure

| Year | Expenditure (Z\$) | HRH share (Z\$) | % |
|------|-------------------|-----------------|-----|
| 1999 | 3,667,544,000 | 1,715,932,000 | 47% |
| 2000 | 6,189,168,000 | 2,327,521,000 | 38% |
| 2001 | 10,933,711,000 | 5,238,122,000 | 48% |
| 2002 | 22,459,863,000 | 8,458,747,940 | 38% |
| 2003 | 73,427,927,000 | 25,009,548,000 | 34% |
| 2004 | 701,209,680,000 | 237,751,318,000 | 34% |

Source: Estimates of Expenditure, Government of Zimbabwe (1999 –2004)

Brain drain and the resultant shortage of health workers worsened from 2000. Consequently, the fall in percentage share of expenditure on human resources has more to do with the fact of a reduced population of health workers and therefore a reduced salaries bill than the deliberate fiscal policies of the public sector.

3.1.2. The private sector

The role of the private sector (for-profit and not for-profit) in health is becoming very significant in Zimbabwe. The proportion of private expenditure in total expenditure on health reached a high of 56.6% in 1997 (WHO 2000) but fell slightly thereafter. About 42% of the expenditure financed personnel salaries and allowances. Missions, municipalities, and industrial / mining corporations, form the largest private sub-sector in health operating on not for-profit basis.

From interviews with MoHCW personnel in this study, estimates were given of thirty-five percent (35%) of national health workers employed in the private sector, with up to three quarters belonging to private not for-profit providers, mainly missions and local authorities that receive government grants as inducement to provide services otherwise the government should provide. Missions come second after the public sector in health worker contributions and in population coverage of health care. According to ZACH officials interviewed, more than a third (38%) of national hospital beds and 68% of rural

bed capacity belong to mission hospitals that cater for the health needs of 70% of rural consumers. A wide variety of local and international NGOs as well as bi-lateral agencies also contribute human resources for health and serve up to 5 million people across often disadvantaged communities (WHO and MoHCW 2002). It is however not possible to ascertain the number of health workers employed by the NGO community and the private for-profit sector because both rarely feed back into the national health information system.

3.2. The domestic production of health workers

The public sector has the infrastructure to train adequate numbers of health workers required to run national facilities without having to import them. All central and provincial hospitals have a long history of producing internationally recognized health professionals like nurses, pharmacists, radiographers and dental technicians. However, the nature of the health professions is such that it takes a long time to train health workers and, if experienced staff is not retained, replacing them becomes difficult no matter what training infrastructure exists. This is especially the case for doctors because there is only one training institution – the University of Zimbabwe (the recently established Medical School at the National University of Science and Technology – NUST – has not yet produced its first graduates). For a variety of reasons that include shortage of tutors and teaching staff, lack of teaching equipment, space and students accommodation, training institutions lack the capacity to increase intakes and outputs. Consequently, the average annual increase in stock of health workers (see *Table 2*) is still not enough to overtake attrition rates.

Table 2: Selected Health Professionals Registered 1985 to 1997

| Category | 1985 | 1990 | 1995 | 1997 | Growth |
|------------------------------|-------|--------|--------|--------|--------|
| Medical Doctors | 1 058 | 1 320 | 1 630 | 1 634 | 54% |
| Dentists | 94 | 131 | 152 | 148 | 57% |
| Pharmacists | 285 | 347 | 499 | 524 | 84% |
| Radiographers | 98 | 166 | 204 | 197 | 101% |
| Nurses (of all grades) | 9 533 | 12 518 | 14 108 | 16 407 | 72% |
| Laboratory technicians | 3 039 | 2 651 | 3 241 | 3 340 | 10% |
| Dental Technicians | 14 | 22 | 33 | 36 | 157% |
| Environmental Health Officer | 77 | 145 | 185 | 198 | 157% |

Source: National Health Strategy for Zimbabwe 1997-2007.

Comparatively more health workers have been trained since independence in 1980. Despite the notable increases (*Table 2*) the shortages of professional staff remain vis-à-vis national needs as well as requirements of the public sector. Records of the Health Professions Council include those in the diaspora as long as they remit membership subscriptions. *Table 2* data could therefore be overstated in terms of the population actually serving in the country and fails to accurately inform about growth patterns in the public sector.

3.3. Distribution patterns of public sector health workers

3.3.1. Rural versus Urban areas

The study revealed distribution patterns that should cause concern to equity-conscious policy makers. Urban areas have almost all (98%) of private for-profit providers and hospital facilities (MoHCW 2004). Yet still the highest allocation of public sector establishment and key professions amongst it (*Tables 2 & 3*) is reserved for the same locations, ostensibly to fill the approved posts. *Table 3* compares the rural and urban distribution of public sector health workers in 2000 for all set and approved posts (establishment), and all professional posts. Among the professional staff, we compared the distribution of doctors and nurses because of their relative contribution to equitable provision of health care. Non-professional staff's (clerical, technicians, domestic, security etc) role in health is appreciated. However, we were not convinced their contribution to services provision impacted so much on equity as did they professional staff.

Table 3: Where are the public sector health workers?

| Location | Establishment | Professionals | Doctors | Nurses |
|-----------------------|---------------|---------------|---------|--------|
| Rural | 30% | 32% | 20% | 36% |
| (Filled post – 2000) | (29%) | (31%) | (40%) | (40%) |
| Urban | 55% | 47% | 71% | 47% |
| (Filled posts – 2000) | (60%) | (55%) | (80%) | (57%) |

Source: Initiatives Inc (2000), WHO and MoHCW (2002), MoHCW (1999)

It was evident that staffing in the public sector is skewed in favour of urban areas. The rural–urban staffing disparities became more glaring (*Table 3*) when we compared the proportions of posts actually filled in 2000. It should be noted that data on staffing and distribution patterns sometimes do not reconcile between the MoHCW, the PSC and independent audits at facilities (Initiatives 2000, WHO and MoHCW 2002). Maldistribution is also exhibited amongst the urban areas with Harare and Bulawayo cities accounting for 60% and 40% respectively for all public sector urban doctors' and nurses' posts. The rest of the smaller cities and towns (about 10) share the remainders but serve larger populations areas as general hospitals and provincial referral centers, However, despite having provision for more staff, the urban public sector facilities are still notorious for congestion and delayed services for patients because not all posts are filled (see *Table 3*).

3.4. Policy implementation gaps

That infant mortality rate reduced from 98 to 60 deaths per 1 000 live births between 1980 and 2004, malnutrition for children under three years of age fell from 22% to 16% in the same period, and immunization coverage increased from 22% in 1982 to 80% in 2004 are achievements in health indicators partly due to a variety of human resource policies in the past 20 years. Evidence from our literature reviews and discussions with key stakeholders however suggest some weaknesses in human resource policies that compromise equity and quality as well as advancement or at least protection of the health gains.

Key informants indicated in the study interviews that some of the policies to increase health worker numbers and their skills mix were shelved or abandoned during the

Economic Structural Adjustment Programme in the 1990s. The International Monetary Fund (IMF) and the World Bank did not exempt the health sector from austerity measures that aimed to rationalize the public service. Instead, retrenchments were effected despite reported shortages with the effect that consumers in previously understaffed rural areas still suffer financial and distance difficulties to access the services of skilled and experienced health workers.

There are still discrepancies between the PSC and MoHCW when it comes to determining the number of health workers needed at public sector facilities, and the public sector structure could be partly blamed for the policy conflict. For instance, that the PSC and not the MoHCW employs health workers create disparities in policies that concern distribution of health workers. In practice, MoHCW determines ideal staff requirements to provide minimum health packages but has no power to increase posts beyond the establishment set and approved by the PSC. Table 4 illustrates the planning gaps between the MoHCW and PSC for key categories of health workers.

Table 4: PSC – MoHCW staffing policy gaps (2000)

| Category | Ideal posts (MoCHW) | Approved posts (PSC) | % gap |
|----------------------|---------------------|----------------------|-------|
| Doctors and Dentists | 1,532 | 690 | 55% |
| Nurses (all) | 11,229 | 8,339 | 26% |
| Nurse Aides | 2,882 | 1,087 | 62% |
| Pharmacists | 369 | 156 | 61% |
| Radiographers | 283 | 136 | 52% |
| Public Lab | 330 | 105 | 68% |
| Dental Tech | 229 | 100 | 56% |

Source: MoHCW (1997b), Initiatives Inc (2000).

For a variety of reasons, and for almost all categories of health professions, the PSC approved establishment is lower than the ideal requirements of the MoHCW. The PSC approved posts are even lower than the WHO minimum standards specified in the Human Resources Master Plan used by the Ministry. In order to adequately perform its obligations, the MoHCW bears the burden of bridging the staffing gaps through donor aid and contract workers funded from internal savings.

Part of the reason for the conception of the Health Services Board (HSB) in 2005 was to ensure that such policies for improved health delivery are implemented. It is an independent entity superior to the MoHCW and strictly concerned with all management aspects of public health including human resources - tasks previously done by the PSC.

4. Discussion and conclusions

Government commitment to national equity in health is spelt out in both the Equity in Health policy (MoH 1980) and its successor strategy document - The National Health Strategic Plan 1997-2007 whose theme is “Working for Quality and Equity in Health”. Both documents emphasize the important role of human resources for equity and improved quality in health. Yet existing health worker distribution patterns are not conducive to realizing the objectives at national level.

One concern is the lack of coordination through the MoHCW of the activities of the many stakeholders (e.g. public, for-profit and not-for-profit providers) who contribute to the national stock of health workers. Duplication of services among the stakeholders in health exists, implying irrational and inefficient use of health workers at national level. Also competition between stakeholders for these workers is very high and the public sector is left to employ the less skilled and inexperienced workers. This could be resolved through sharing of information on the numbers, skills mix and activities of health workers between stakeholders as an input to rational human resources planning at national level (WHO 2002).

Planning for equitable distribution of health workers is compromised by the lack of basic data to start with. The system gives little effort to elevate human resources to be in the periodical returns expected in the national health information system. Even where there have been such submissions, the effort is largely manual because there is no computer equipment dedicated to collating health human resources in the facilities. This study noted that using data from the HPC does not assist much for planning purposes. The HPC keeps a record of professionals registered to practice but not of those who are actually present in the country.

The conceptual definition for equity used in this study preferred distribution of health workers to benefit the poor more than the rich and to serve more in rural than urban areas because most of the poor and majority of the population (70%) are in rural areas. This study established that the public sector deployment policies are biased towards capacity of facilities rather than the population distribution matched with needs. There is always effort to fill posts at Central and Provincial Hospitals with higher establishments than the district and lower level facilities. This is regardless of whether the former serve smaller geographical areas or provide preventive services.

What is desirable are pro-poor and needs-based distribution policies which could be executed by putting a moratorium in expansion of staffing levels in urban areas and prioritizing district and lower level facilities. Reassigning municipalities and local authorities to provide more primary care services in urban areas potentially releases workers from Central Hospitals for redeployment to the districts. Then, improved conditions of services in rural areas and other incentives (such as better housing, rural allowance, communication and other infrastructure) are needed to influence the redeployed health workers to stay. The Ministry of health officials noted in interviews that lack of such incentives pushes health workers away from rural areas and out of the public sector. The Ministry however has no capacity to resolve it, as appropriate development policies are responsibilities of other government departments. It remains to be seen if the recently introduced Primary Care Nurses trained for rural deployment will stay there in the absence of improved conditions of service.

Despite its staff retention strategies, the public sector is likely to continue experiencing shortages and maldistribution of health workers because of the pull of private for-profit practice and migration. It is the wish of most doctors, nurses and pharmacists to do private practice or migrate to greener pastures for the status and financial rewards associated with it. In their country studies for the WHO, Stilwell et al (2004) noted that for Zimbabwe, the need for better salaries was the most important push factor for health workers migration.

Two scenarios however seem to favour public sector retention of especially doctors and nurses. First, the government has been over the years investing in incentives to make the public sector competitive with the private sector. Since 2000, interviews with Ministry of Health officials reported that some doctors and nurses were enquiring to rejoin the public sector from private practice. Second, the rapid growth of private for-profit practice seems to have reduced the industry's profitability, especially to the junior doctors who now have difficulties to enter the market. Most junior doctors now elect either to remain in the public sector or do dual practice.

This study also exposed the pitfalls of dual management of health workers by the PSC and MoHCW. On one hand, the establishment managed by the PSC is not regularly expanded to keep pace with expansion of the health sector as well as increased demand due to population growth. Public Services Commission interviews indicated that the last review of health sector establishment was in 1990, but posts were never increased because the IMF and World Bank discouraged it as part of the Economic Structural Adjustment Programme.

On the other hand, the MoHCW requires more than twice the approved establishment to achieve minimum staffing levels (see *Table 4*) necessary for facilities expansion and responding to epidemiological trends and the challenge of HIV/AIDS. While training institutions can increase outputs, the public sector should complement expanding establishment to create posts against which the graduates are offered employment opportunities. The Ministry could only recommend that the PSC should employ more health workers but itself has no power to recruit civil servants. This partly explains the setting of HSB to streamline planning and management of health human resources.

The HSB that health workers lobbied for was set up in November 2005 with mandate to implement health sector reforms suggested by the MoHCW and other stakeholders. Our first recommendation is for the government and PSC to facilitate smooth transitional arrangements for the HSB to assume its new role. The danger to lose more health workers because of frustrations inherent in managing transitions exists.

Secondly, we recommend the public sector to take advantage of the declining fortunes in private for-profit practice by investing more to assume a competitive advantage on incentives provided to key health professions in order to retain them in public sector. The trend is likely to be perpetuated as the saturated private for-profit industry becomes unaffordable by most patients due to poor performance of the country's economy.

Achieving adequate staffing levels in the public sector cannot be done overnight. But still the system should sustain the achieved health gains. One way is to increase productivity of the available human resources. Acute as the shortage may be, we recognize that improved performance of the same numbers could in the short term minimize inequalities in health (WHO 2005). This includes reducing absenteeism by health workers - manifested through private practice during government working hours, selling personal wares in offices and other idle engagements that do not extend health benefits to patients.

We note that many of the inputs necessary for equitable distribution of health workers lie outside of the MoHCW's control. Ministries responsible for housing, transport and other infrastructural development could play an important role by creating the conditions necessary for health workers to stay longer in needy areas. In this regard, it is hoped

that the recently created Ministry responsible for Rural Housing and Amenities will respond to the challenges faced by health workers in the rural areas. Other obvious benefits from inter-sectoral coordination include optimal utilization of available health workers to avoid situations where multiple NGOs and other stakeholders are concentrated in one or two districts, doing similar activities as observed by WHO (2002).

The results summarized in this paper show the different dimensions of equity impacted by the distribution of public sector health workers in Zimbabwe. Key issues emerging from the analysis point to:

- (iv) the long fruition time for many initiatives taken to improve the maldistribution of health workers;
- (v) the importance of involving other sectors and not just the MoHCW in formulating deployment and distribution policies for health workers; and
- (vi) the policy gaps between the MoHCW and the PSC in matters of planning for increased numbers and distribution of health workers.

Given the complexity of factors influencing the availability of health workers in public sectors in general, the HSB would greatly benefit from experiences of other countries that have had operational Boards over the years. Ghana and Zambia have had operational health boards to provide comparative experiences from which Zimbabwe could benefit. Other regional bodies like EQUINET provide opportunities to share information on the dimensions of human resources in achieving equity in health care and services provision. Ultimately, investment in human resources is the largest component of all health budgets, a fact that demonstrates its critical contribution to improved health for the poor and disadvantaged.

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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.

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