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# The Impact Of Health Sector Reform on Public Sector Health Worker Motivation in Zimbabwe

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*PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.*

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# Abstract

During the past decade the economic situation in Zimbabwe has deteriorated significantly. Public sector health care workers have gone from being high status and relatively well paid members of the community to workers struggling to get a living wage from their jobs. This paper describes the specific policy measures that the Zimbabwean government has recently implemented to try to improve health sector performance, and promote higher levels of motivation amongst public sector health care workers. The overall reform package is to include financial reforms (user fees and social insurance), strengthening of health management, liberalization and regulation of the private health sector, decentralization, and contracting out. Unfortunately, the process of reform implementation in Zimbabwe and the government's poor communication with workers, combined with a conflict between local cultures and the measures being implemented, has undermined the potentially positive effect of reforms on health worker motivation. Workers perceived reforms as threatening their job security, salaries, and training/career advancement opportunities, and feared ethnic and political influence on new employment practices under a decentralized system. Worker demotivation has been expressed in terms of strikes, unethical behavior, neglecting public sector responsibilities to work in private practice, and high turnover.

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# Acronyms

<b>DHMB</b>	District Health Management Board
<b>DMO</b>	District Medical Officer
<b>ESAP</b>	Economic Structural Adjustment Programme
<b>GDP</b>	Gross Domestic Product
<b>MOH&amp;CW</b>	Ministry of Health and Child Welfare
<b>PSRC</b>	Public Service Review Commission
<b>ZIMA</b>	Zimbabwe Medical Association
<b>ZINA</b>	Zimbabwe Nurses Association



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# Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance “knowledge and methodologies to develop, implement, and monitor health reforms and their impact. This goal is addressed not only through PHR’s technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities.

The research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- ▲ Analysis of the process of health financing reform
- ▲ The impact of alternative provider payment systems
- ▲ Expanded coverage of priority services through the private sector
- ▲ Equity of health sector revenue generation and allocation patterns
- ▲ Impact of health sector reform on public sector health worker motivation
- ▲ Decentralization: local level priority setting and allocation

Each major research project comprises multi-country studies. Such cross-country comparisons will cast light on the appropriateness and success of different reform strategies and policies in varying country contexts.

These working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work emanating from the Applied Research program. The final reports will be disseminated by PHR Resource Center and via the PHR website.

Sara Bennett, Ph.D.  
Director, Applied Research Program  
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# 1. Introduction

Several countries in Africa have embarked on health reform, but most research has focused on the impact of reforms on recipients, particularly vulnerable groups. Very little has been written on the impact on health worker motivation. The health sector is labour intensive and the success of the reforms depends on, among other things, the behaviour of those implementing the policies on the ground. Research in developed countries has shown, for example, that 80% of health costs in hospitals are a result of doctors' diagnosis and therapy patterns (Dohler, 1989). Health workers' motivation, manifested in their behaviour in the work place, greatly affects the outcome of health reforms.

This paper examines the impact of health reforms on health worker motivation in Zimbabwe. More specifically, it reviews the various elements of the reforms and briefly comments on their objectives. It proceeds to analyse their impact on the organisational structure, work culture, procedures and processes, material resources, human resources, and remuneration. Lastly, it evaluates the impact of the above factors on health worker motivation and makes suggestions for further work.

By 1987, Zimbabwe's economic situation had deteriorated significantly, exacerbated by inappropriate policies and excessive public sector spending. The economy was experiencing an annual inflation rate of 25%, a budget deficit of 10% of gross domestic product (GDP), a government debt of 53% of GDP, and rising unemployment. In 1990, the government introduced an Economic Structural Adjustment Programme (ESAP), also commonly known as the Economic Recovery Programme, on the advice of the International Monetary Fund (IMF) and World Bank as a way of managing the serious economic crisis. The essential aspects of ESAP are: reduction of public spending; removal of subsidies; removal of administrative controls; privatisation; good governance; and upholding of human rights (Chakaodza, 1993). All government departments had to adapt their policies to reflect the above aspects and in the Ministry of Health and Child Welfare (MOH&CW), these policies constitute the health reforms discussed in this paper. Reducing public spending entailed, among other things, retrenchment from a bloated civil service and budget cuts for most departments, including MOH&CW. A Public Service Review Commission (PSRC) revealed in 1989 that the civil service was too big, inefficient, cumbersome and unresponsive to the needs of the public and its workers and recommended its reform. The government decided to implement the PSRC recommendation on civil service reform simultaneously with the ESAP, starting in 1990 (Makumbe, 1997). The first five-year phase of ESAP ended in 1994 and the second one was launched in 1995.

Expenditure on health was highest in the early 1980s, but slowed down markedly towards the end of the decade due to severe fiscal constraints faced by the government. Zimbabwe's achievements in health up to 1988 were described as impressive, but from then on the health outcomes and the performance of the health services started deteriorating (Davies, 1988; World Bank, 1992). By the late 1980s, it had become apparent that the 5% of the total government budget allocated for health was inadequate to sustain health programmes, especially as 90% of the population was not paying for health care (World Bank, 1992). An assessment of the cost-recovery mechanisms at government health institutions found them weak and ineffective. The inefficient collection of fees at bigger hospitals meant that many who were not eligible received free health care. All health charges were set at lower levels than the actual cost of services and people's capacity to pay. All this seriously reduced the government's revenue and finance capacity (World bank, 1992). Due to economic difficulties and poor management, all government health institutions were experiencing crippling shortages of essential resources such as drugs and equipment. The health reforms were intended to address these problems.

The main sources of the information presented in this paper include: observations at the two big government hospitals and private institutions in Harare; in-depth discussion with senior MOH&CW officials and leaders of professional associations; officials of the Zimbabwe Congress of Trade Unions; individual and group discussions with health workers; discussions with political scientists; MOH&CW official documents; consultants reports; newspapers; and theses.

Section 2 characterises the working conditions, the work culture and the state of health worker motivation in the MOH&CW prior to 1990. Section 3 outlines the main objectives and thrusts of health reforms, while section 4 closely analyses the new organisational structures, work culture, procedures, human resources, resource availability and their potential effects on health worker motivation. Section 5 discusses the extent to which health workers were informed or consulted about the reform programme. Section 6 assesses the overall impact of the health sector reforms on worker motivation. Section 7 concludes by summing up the lessons learnt on health worker behaviour and motivation in Zimbabwe and suggests areas for further research.

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## 2. Work Culture and Motivation Prior to Reforms

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### 2.1 Working Conditions Prior to Reforms

Up to the mid-1980s, the Zimbabwean economy was relatively strong and the country was an attractive destination for professionals from all over Africa, Eastern Europe, and the Indian sub-continent. Professionals and doctors, in particular, enjoyed a high social and economic status and had a life style to show for it. New medical graduates could buy a second hand car, a house in a high income residential area, and offer economic support to siblings and parents. By the end of the decade, this was no longer possible because of the deteriorating economic situation but those expectations persisted.

A review of working conditions for government health workers before the introduction of health reforms showed that conditions were almost consistently poorer than those offered by competing institutions that employ MOH&CW leavers. This was confirmed by research on nurses (Msika, 1989), pharmacists (Mebe, 1989), dental staff (Patel, 1987), radiographers (Rugonye, 1990), nurse tutors (Mahlangu, 1989), and all health personnel in Matebeleland South (Moyo et al. 1989). Over 80% of the MOH&CW leavers were earning higher salaries than in MOH&CW (Mutizwa-Mangiza, 1991).

Competitors offered better salaries, regular working hours, and fringe benefits, among them housing loans, school fees and transport allowance. About 72% of MOH&CW employees worked unsocial hours, including weekends, night duty, after hours and public holidays. The largely female workforce found the inflexible and unsocial working hours and the threat of rural posting incompatible with family responsibilities. This was the third most frequently mentioned reason for considering leaving the MOH&CW (Mutizwa-Mangiza, 1991). The allowance paid for working unsocial hours was considered inadequate and was the cause of a long-running dispute between the MOH&CW and its employees. It was one of the causes of the 1988, 1989, 1994 and 1996 doctors' strikes, the 1981, 1990 and 1996 nurses' strikes, and the 1993 laboratory technicians' and radiographers' strikes.

On the other hand, job security, opportunities for career advancement and further training were perceived to be better in government. Many health workers, particularly the older ones, valued MOH&CW employment because of job security. The government offered better opportunities for further training for some professional categories, although the chances were reduced for most belonging to big categories such as nursing. Most health workers found the selection process for further training, particularly overseas, lacking in transparency. Most health workers, particularly nurses, were dissatisfied with the allowances (10 Zimbabwe dollars per month) offered after post-basic qualifications. They were perceived as not matching the new duties and responsibilities assumed after the training. All health workers were unhappy with taxation of all allowances and felt the final remuneration was a mockery of the effort involved.

For many professional categories, the MOH&CW offered opportunities for career advancement. The career structure for nurses and doctors, in particular, had several promotional levels, although the nursing career structure had limited positions at each of the higher levels. The medical profession had the best opportunities for both further training and career advancement. Basically, any doctor who wanted to specialise in an area of critical shortage could do so almost immediately, while the rest could

embark on further training after serving two years in the less desirable rural areas, although well connected individuals did not have to endure this. The medical profession was the most dominant profession in the MOH&CW and held all the top positions, including that of Minister, Deputy Minister, Secretary for Health, Principal Medical Director and the Director of Maternal and Child Health. All the other functional heads, for example, the Director of Pharmaceutical Services and the Director of Nursing Services, reported to the Principal Medical Director, a doctor. In the period 1987 to 1991, even the Director of Health Manpower and Training was a medical doctor. This was a source of great dissatisfaction for other professionals who felt that their contribution was not appreciated and their education and experience were not given due weight.

Rural posting was a major source of dissatisfaction because of the poor infrastructure at most of these stations, professional isolation, the possibility of family separation, maintenance of two homes and lack of rural/“bush” allowances.

The MOH&CW, like other government departments, had an oversized bureaucratic structure which inhibited effective decision-making, was characterised by a top-down approach to planning and weak guidance from the centre, and was slow and unresponsive to workers’ needs, particularly those working at rural stations (Government of Zimbabwe, PSRC, 1989). Most health workers expressed dissatisfaction with management at head office while 39% felt that their supervisors were very poor on rewarding work well done (Mutizwa-Mangiza, 1991). Most, however, were satisfied with their immediate supervisor. In terms of work culture, most were aware and committed to the ministry’s guiding principles of “Equity in Health” and “Health For All By the Year 2000” and worked diligently towards the achievement of these goals (Mutizwa-Mangiza, 1991). The majority of health workers were dedicated to their work, with a strong commitment to delivering the best service to their patients (Mutizwa-Mangiza, 1991).

Up to 1990, government health workers could not legally practise their profession privately, even during off-duty hours. By 1986, the Public Service Commission and the MOH&CW were aware that many full-time government consultants were practising medicine privately but no action was taken (Mutizwa-Mangiza, 1996). If nurses or other health workers practised privately, it was insignificant and did not merit comment from the MOH&CW or the media. An amendment of the Medical, Dental and Allied Professions Act in 1987 made it mandatory for medical graduates to work for the government for seven years after graduation (commonly called the “bonding contract”) and two of these were to be spent at rural stations. In order to further tighten entry into the private health sector, the government drafted the Health Institutions and Services Bill, 1989. For the first time, all private health institutions had to be registered following approval by the Minister of Health who was supposed to set out the terms and conditions for registration and provide regulations stipulating standards of construction, location, essential equipment, and staffing levels. An inspectorate was to be established to ensure that all the above were observed. In addition, every private institution had to obtain an annual licence after paying a fee. These proposed policies led to the first ever doctors’ strike in 1988, followed by another in 1989. The Health Services and Institutions Bill was abandoned in the face of this fierce opposition. As part of the post-strike concessions, in 1990 government-employed consultants were allowed to practise privately for two afternoons per week after obtaining permission from the Secretary for Health. All middle level doctors, heads of health institutions, and government-employed dentists were given a professional allowance in lieu of income from private practice.

Health workers, like all civil servants, could not unionise, but could join professional associations. In addition, health workers were regulated by the Essential Services Act which prohibited them from taking any industrial action. This situation made it difficult for health workers to register their grievances with their employer. The Zimbabwe Nurses Association (ZINA) was able to present its grievances to the country’s president because the first lady was the nurses’ patron and she facilitated

ZINA's audience with the president. He frequently directed the MOH&CW management to address nurses' grievances as a matter of urgency, which was deeply resented by MOH&CW senior officials and most other health workers. Medical doctors were not cohesive due to conflict of sectional interests within the profession, but their elevated social status in Zimbabwean society often forced government to concede to their grievances. This piecemeal approach to addressing grievances distorted the MOH's remuneration structure, as doctors' and nurses' salaries were reviewed more frequently than those of other groups who did not have patronage or high social status to back their cases.

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## 2.2 Evidence of Motivation Levels Among Health Workers

At independence in 1980, nurses joined the wildcat strikes which rocked the nation in 1981, in protest at poor salaries and allowances. They went back to work on the promise that these would be addressed, but this was not done until after another strike in 1990. The strikes of 1988, 1989 and 1990 by health workers clearly pointed to underlying frustration and dissatisfaction with working conditions. The strikes forced government to reduce the bonding period for doctors and shelve the Health Institutions and Services Bill. More importantly, for the first time, doctors were offered call duty, transport, and a housing allowances.

During the 1989 doctors' strike, junior doctors expressed their frustration at working in an environment in which almost all the necessary resources were in short supply. In an interview, they complained about being continually called upon to make ethically unacceptable choices such as denying one baby an incubator and giving it to another because of the shortage in the hospitals. In an interview, the president of the Hospital Doctors' Association revealed that because of the doctors' failure to obtain all their demands after the 1989 strike, the group decision was to leave government employment and the country after completing their internship, in total disregard of the bonding contract. By the end of 1990, almost all the junior doctors who participated in the strike had done just that.

Another indication of poor motivation was the relatively high turnover from government to private institutions as blacks joined the private health sector which had previously been closed to them (Government of Zimbabwe, 1983a:5). Physiotherapists, pharmacists, and hospital equipment technicians had turnover rates of over 25% per year. Over 80% of the leavers were practising their profession in competing organisations, which suggests that leaving the MOH&CW was due to dissatisfaction with conditions of service in that organisation rather than with the profession *per se* (Mutizwa-Mangiza, 1991). The Ministry, which had significantly expanded its services after independence in 1980, found itself seriously short of staff and was forced to recruit large numbers of expatriates. In 1990, the beleaguered MOH&CW hired a consultant to examine the problem of high staff turnover for all health professional categories, a clear indication of the seriousness with which the issue of health worker motivation was regarded (Mutizwa-Mangiza, 1991).



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## 3. Main Thrusts of the Reform Program

The proposed health reform programme comprised the following key components: health financing, management strengthening, decentralisation, regulation of the private medical sector, and contracting out of ancillary services. Although health worker motivation was clearly a problem for MOH&CW, as we have seen above, none of the health reforms was specifically targeted to motivate health workers. Some had the potential of doing so, but this was secondary to the main objective of introducing these reforms.

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### 3.1 Financial Reforms

In order to reduce public spending, the health budget was cut considerably. By 1994, the health budget had declined by 30% (MOH&CW, 1997). This made it essential for the MOH&CW to raise revenue and improve efficiency and effectiveness to enable it to maintain existing health services without abandoning its policy of achieving equity in health. The main policy objectives and means for reforming health financing are discussed below.

The first objective was to raise revenue. This was done through stricter billing and collection of revenue at the facility level from 1991 onwards and increasing user fees from 1994. The capacity of the accounting staff to carry out the above duties more effectively was strengthened through further training. The second objective was to improve efficiency by stringently enforcing the referral procedures and rationalising user fees in keeping with the level of the facility. In 1994, the largest hospital in the country, the Parirenyatwa Group of Hospitals, was allowed to keep a proportion of its revenue and in 1996 the Cabinet agreed to the creation of Health Services Funds in which all facilities could keep the collected revenue. The latter could be used to meet any locally determined needs, but not staff salaries.

The third objective was to improve equity in the provision of health by raising the exemption threshold from Z\$150 to Z\$400 in order to include more people, create mechanisms to enable the poor to claim from the Social Dimension Fund, and abolish the collection of user fees at rural institutions in 1995. The MOH&CW is currently planning to develop a Social Health Insurance Scheme to cover the formally employed and those working in the informal sector. From the above stated objectives, it is clear that motivating health workers was not an important consideration in the formulation of the reforms although some of them could have a positive impact on health worker motivation.

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### 3.2 Health Management Strengthening

The management development program has been going on since the first phase of the reforms and is set to continue until the end of this phase of the reforms at least. The objective is to reorient managers, inform them of the different aspects of health reform and equip them with skills to perform their duties effectively and efficiently. Many managers in the MOH&CW did not have management qualifications or in-service training in management, and most were not carrying out their duties effectively and efficiently. Top, middle-level and shop-floor health managers and Rural District Council officials have been attending management training courses to enhance their skills in financial

systems, human resources, equipment and supplies, planning and information management, and to educate them on the reform process.

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### **3.3 Liberalisation and Regulation of the Private Health Sector**

One essential aspect of the health reforms was the liberalisation of the private health sector. The government fully accepted the role of the private health sector in health provision and relaxed the constraints on its expansion. Many private hospitals, nursing homes, and clinics mushroomed. The Public Service regulations which formerly prohibited all civil servants, including health workers, from working privately in their own time were relaxed. This was primarily intended to retain civil servants. The MOH&CW had lobbied the Public Service Commission and the Cabinet on this issue for years with the primary intention of retaining health staff, particularly doctors.

As part of the health reforms, the MOH&CW developed legislation to regulate the liberalised health sector through: mandatory accreditation; regulation of technological and capital investment; monitoring health financing practices; strengthening the capacity of the Health Professions Council; regulating the health insurance industry; and creating frameworks for evaluating and approving private hospital construction. The rescinded Health Institutions and Services Bill had been drafted for this purpose and, with its rejection, the private health sector was operating with almost no regulation at all. To rectify this situation, the MOH&CW drafted the Health Professions Bill and the Medical Services Bill, both of which are still to be approved by parliament. Thus, although the private health sector was liberalised, no regulatory mechanisms have been instituted as yet.

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### **3.4 Decentralisation**

The policy of decentralisation was adopted with the objective of promoting and strengthening democracy and civic responsibility, enabling public participation in governance and development, and achieving greater efficiency and effectiveness of operations (MOH&CW, 1997). As with the other health reform policies, health worker motivation was a secondary rather than primary consideration in the adoption of the policy of decentralisation.

Decentralisation entails the transfer of functions and authority from central government to Rural District Councils. A District Health Management Board, which is a committee of the Rural District Council, will be responsible for managing and coordinating all the functions of the health sector transferred to the local authority. A Provincial Health Executive, headed by a Provincial Medical Director, will ensure that all the health services in the province are delivered in accordance with the national health policies. The MOH&CW will continue to set appropriate standards and guidelines of operation. Among the functions to be decentralised is the hiring of all staff and administration of their conditions of service, including their salaries and allowances.

The decentralisation process has not started, although the MOH&CW plans are at an advanced stage. Implementation is supposed to be carried out simultaneously for all government departments, but the other departments have not yet finalised their plans. The plans were temporarily shelved before the 1995 general elections, for fear they would cost the ruling party votes. Although the government has been talking about decentralisation for a long time, the policy was only formally announced at the end of 1996. The Ministry of Local Government and Housing Construction, under which the Rural District Councils fall, is in the process of strengthening the capacity of its officials to assume the new responsibilities.

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### **3.5 Contracting Out**

The objectives of contracting out are to reduce the number of civil servants and public spending, promote the indigenous business sector, and improve efficiency and effectiveness of service delivery and service management. The services to be contracted out are laundry, catering, maintenance of grounds, and security. Hospital or district management boards will have the responsibility of contract specification, tender management, evaluation, and negotiation.

Although the policy to contract out was adopted by government in 1994, the plans were abandoned until after the presidential elections of 1996 because government feared antagonising its supporters, who constitute the majority of workers in the above services. No services have been contracted out yet, although the tenders for contracting out security services have been floated. The Ministry officials are still working out the details of how to set quality standards and supervise the winning contractors.



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## 4. The Impact of the Reform Program on Health Worker Motivation

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### 4.1 Changes in Organisational Support Systems

#### 4.1.1 Organisational Structure

An assessment of the impact of the health reforms can only be speculative since most of them have not been implemented and are still at the planning stage. According to the decentralisation plans, the Rural District Councils will be responsible for the provision and management of the core health services provided at district level. A District Health Management Board (DHMB), which will include stakeholders and members of the community, will manage and coordinate the provision of all health services within the Rural District Council area. The Chief Executive of the Council and the District Medical Officer (DMO) will be full members of the board and executive responsibilities of the board will be vested in the DMO, a doctor. A District Health Executive comprising a Health Services Administrator, an Environmental Health Officer, a Pharmacist, and a Nursing Officer will constitute the management body and will be answerable to the District Health Management Board above it.

Decentralisation changes the structural location and relationship of the existing district health staff, with the possibility of altering the current perception of professional equity and team spirit, as one cadre, the doctor, will be higher than others on the new organogram. The organisational structure under decentralisation enhances the dominance of the DMO, a doctor, who becomes a member of the DHMB, from which the other professional groups are excluded. Other health workers are already demoralised by the fact that doctors are always in charge of all health institutions above the health centre, regardless of how much training and experience other health professionals have. Nurses regard themselves as one of the cadres whose basic training programme fully incorporates a management dimension and yet are never given full responsibility.

The feeling of inequity among health workers is exacerbated by the exclusion of doctors' salaries from transfer to the administration of Rural District Councils, like those of other health workers. The proposed organisational structure is supposed to speed up the decision-making process and replace the feeling of powerlessness generated when health teams wait for decisions from head office. Inclusion of health workers and members of the community in the decision-making and implementing structures is supposed to generate a more democratic and accountable style of management and create a culture of ownership and partnership among providers and community/consumers of healthcare. The MOH&CW will however have to embark on a community education exercise and also reorient ordinary health workers to move away from the top-down medical approach to enable them to work with the community as partners. At the moment, there is a big social distance between health workers and most patients, especially the rural based ones.

### **4.1.2 Procedures and Processes**

An assessment of the impact of proposed reform procedures and processes has, to a large extent, to be tentative, as most of them are still at the planning stage. Effective and efficient operation of Health Services Funds should have a positive influence on health worker behaviour. Firstly, health workers will participate in decision-making on use of the Fund. Secondly, it is hoped that this will improve the availability of resources and reduce the frustration associated with working in an environment with severe resource shortages.

With regard to contracting out, the decision to give the first preference in the awarding of contracts to existing workforce members who form a company or cooperative, or to a company that absorbs current workers, has the potential of improving health worker morale. MOH&CW officials noted that there was a lot of hostility when the policy was initially suggested, with most workers preferring early retirement packages. However, many workers now view the idea more enthusiastically and are in the process of organising themselves in order to place their tenders. Inclusion of a health worker with relevant expertise in the tender board is likely to engender goodwill among health workers. In addition, this may breed a new sense of ownership, and improve service delivery.

### **4.1.3 Human Resource Policies**

A job evaluation of the whole civil service carried out as part of the civil service reform revealed that government salaries were lagging behind those of parastatals by 84% and those of the private sector by 172% (Government of Zimbabwe, 1995b). Salaries were subsequently increased by 60%, to be awarded over a three year period. When announcing the salary increments, the Minister of the Public Service, Labour and Social Services stated,

These significant improvements in the conditions of service should now stop people from leaving the service. The “greener pastures” are now in the Public Services of Zimbabwe (Government of Zimbabwe, 1995b: 6).

Salary increases were received positively by all health workers, but the government’s failure to pay the increments in 1996 led to a general strike by all civil servants that year. Many health workers were dissatisfied by the grading system, which placed some lower than they had expected. For example, physiotherapists were placed below workers with lower academic qualifications and most are leaving for the United States where they describe the working conditions as “superb” (Herald, 27/11/97).

A recent motivational survey found that 74% of health workers consider their salaries as very poor compared to 57% who thought so before the reforms (Initiatives Inc., 1998; Mutizwa-Mangiza, 1991). Most of them advised government that if MOH&CW wants to retain staff it should improve salaries, allowances and benefits, i.e., pay a “living wage.” All rural-based civil servants were awarded a rural allowance while the urban-based ones were awarded a transport allowance for the first in 1996. Health workers are aggrieved by the government’s refusal to award a risk allowance which they demand for working in a risky environment, handling patients infected with HIV/AIDS and tuberculosis. Clearly, dissatisfaction with remuneration is going to remain given the higher rates offered by competitors and the galloping rate of inflation in the country.

The government’s proposal to link salary increments, advancement, promotion, and annual bonus (13th cheque) to performance was vehemently opposed by all civil servants, who went on strike in protest in 1996. This was subsequently shelved and the government’s intention of implementing this in 1997 was thwarted by threats of another strike. The MOH&CW officials are still working on the

objectives by which health workers' performance will be appraised. Prior to this, performance targets or objectives were not usually identified for most civil servants. In addition, health workers are opposed to the idea of performance-related promotion and remuneration on the basis that the present crippling shortages of staff and resources hardly represent an optimum working environment in which set objectives can be achieved. The MOH&CW has serious staff shortages in all professional categories, including 2000 vacancies for nurses.

Health workers contend that a performance appraisal system that has an impact on remuneration will give rise to conflict between the supervisor and his/her junior and has the potential of promoting patrimonialism as some supervisors will base their reports on kinship considerations rather than merit.

Linking salary increments, promotions, and bonuses to performance is feasible for most health workers once acceptable instruments for doing so are in place, because they have effective supervision. However, an audit of the MOH&CW found that individual employee performance appraisals for health workers were often not completed appropriately and most supervisors gave good reports even where bad ones were called for. The supervision and performance appraisal of junior doctors is clearly very unsatisfactory and the MOH&CW has to deal with that aspect before introducing performance-linked remuneration and promotion. Nurse supervisors are increasingly too busy themselves because of the staff shortage, and they are unable to effectively teach, supervise, and evaluate their juniors' performance. The MOH&CW will have to address the issue of consultants' employment terms, stating the minimum number of hours they have to work, distribution of workload between them and their juniors, and the minimum level of supervision required for junior doctors, otherwise this policy of performance-related pay cannot be effectively implemented for doctors. In desperation, the MOH&CW hired consultants in 1998 to conduct a motivational survey and determine optimal staffing levels and optimal workloads for the different categories of health workers.

As pointed out earlier, human resources is one of the functions to be transferred to Rural District Councils when decentralisation is implemented. An evaluation of the impact of decentralisation is premature, but it is a cause of considerable anxiety among health workers. They are anxious about the security of their salaries, allowances, and pensions under Rural District Councils. The Councils do not have a good management record, as confirmed by the fact that during the writing of this paper almost 50% of them were under suspension for mismanagement and incompetence. Some of them have not been able to pay nurses' salaries for months due to financial constraints.

The general perception in Zimbabwe is that employment by Rural District Councils is insecure. The prevailing serious staff shortage at government institutions has enhanced job security for health workers. Health workers working for Rural District Councils are sometimes summarily and arbitrarily dismissed by councillors for no good reason. Not surprisingly, there are grave concerns about job security after decentralisation. Job security was one of the most frequently mentioned reason for remaining in the civil service by many health workers (Mutizwa-Mangiza, 1991) and under decentralisation, this will no longer be guaranteed. Further, there is uncertainty about opportunities for career development and further training, as these will no longer be centrally coordinated. There are fears, particularly among nurses, that employment practices of the Rural District Councils will be affected by ethnic and political considerations. Some politicians in Matebeleland, for example, have been arguing that only those who speak the Ndebele language should work in the province. When allocation of civil service jobs and training are locally determined, it is likely that only those from that region will be considered. When the government announced that recruitment to the multi-disciplinary provincial training schools could be done locally, the Provincial Governor of Mashonaland West announced that ruling party officials would be involved in the selection process. Given the way the ruling party operates, it is highly likely that they will favour relatives of party stalwarts. At the same time, many Zimbabweans are not keen to work in their areas of origin because of the economic

expectations of the extended family. Some health workers are resigning from the MOH&CW due to the uncertainty surrounding employment under decentralisation. To counter this, there is an on-going vigorous donor-sponsored capacity building exercise intended to strengthen the management capacity of the Rural District Council officials.

#### **4.1.4 Resource Availability**

The reduction of the health budget allocation had a serious negative impact on the availability of all resources in the health sector. The health workers' ability to do their work effectively has been seriously constrained by the lack of essential equipment, shortage of drugs and other resources such as linen. Most of the government hospitals are overcrowded, with many floor beds particularly in the maternity wings. In 1996, the health sector was so strapped for cash that relatives had to bring food for patients admitted to Mpilo Central and Gweru Hospitals.

In 1993, a Parliamentary Committee (Parliament of Zimbabwe, Vote No. 15-1990-1991) investigating the state of equipment in government institutions found obsolete and non-functioning equipment in intensive care units, central sterilising departments, x-ray departments and most wards. Doctors expressed frustration at working in an environment which does not allow them to diagnose and treat effectively because of the above situation. One doctor stated that when unable to carry out essential diagnostic tests,

I end up just prescribing broad spectrum drugs hoping that they will somehow treat whatever condition the patient has. More often than not the treatment is effective, but at the end of the day a doctor does not know what one is dealing with (Mutizwa-Mangiza, 1996: 158).

Similarly, doctors' ability to prescribe is constrained by the unavailability of drugs in government hospitals and, in some cases, the patients' inability to afford them. A junior doctor explained,

A lot of drugs are not available. This is very frustrating. Initially, I was very diligent but I gave up. I used to run around looking for drugs for patients in the intensive care unit (Mutizwa-Mangiza, 1996: 162).

Some health workers have left government service because of shortage of resources, breakdown of essential equipment, and problems with back-up services in general (Initiatives Inc., 1998). For example, some of the doctors carrying out heart surgery in South Africa are Zimbabweans who left due to the closure of Zimbabwe's heart programme in 1990.

Although all health facilities have had the Health Services Fund since 1996, there has not been much change in the availability of material resources. Health officials insist that it is too early to expect meaningful changes in resource availability. It appears that some local managers were scared to use the newly accorded authority to make spending decisions at the local level, while others did not know how it was supposed to operate, months after the introduction of the Health Services Fund. Shortages of resources also occur because of poor planning and prioritisation at the local institutions due to inexperience on the part of local management. MOH&CW officials gave an example of one facility where the local management saved the revenue and invested it in a long-term deposit account, yet the facility lacked basic resources such as drugs and bandages. It is not surprising, therefore, that a recent motivational survey found that health workers are frustrated by the gross shortage of resources, even at the Parirenyatwa Hospital, which has had a Health Services Fund since 1994 (Initiatives Inc., 1998).

The MOH&CW is reinforcing the training of accounts officers and local management in the utilisation of the Health Services Fund. On the other hand, revenue retention may not make a difference in resource allocation for hospitals like Harare Hospital and rural ones, since the majority of the patients treated there are non-paying.

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## 4.2 Worker Experience of Outcomes

Health workers get an annual performance appraisal report or are given one at the end of a rotation in one department. Senior doctors pointed out that the seriousness of the performance appraisal report was greatly eroded by government officials after independence. Previously, the performance appraisal report given by the immediate supervisor genuinely reflected the supervisor's perception of the junior's performance and were an important feedback and led to behaviour change where it was called for. A good appraisal report was crucial for applying to join good medical firms during internship and after, for embarking on post-graduate training and career advancement. The value of appraisal reports declined when promotions were effected more often on the basis of political considerations rather than merit. Medical rotations were no longer linked to reports but became automatic.

The appraisal system can only be effective if appraisals are perceived as a genuine reflection of performance by the recipient. In the case of doctors, the juniors and post-graduate medical students expressed grave reservations about reports produced by most of their seniors. In their view, most senior consultants cannot effectively assess them as the former spend most of their time in their private clinics and hardly have time to observe the latter at work. Junior doctors stated that seniors are not there to teach or supervise them and they learnt essential procedures from peers at the same level. More recently, junior doctors at two of the largest hospitals in the country threatened to boycott rotation in the paediatric department because the consultants systematically give bad reports even when the junior doctors look after the patients on their own without any supervision (Herald, 6/2/98).

Some junior doctors described some departments as "notorious" for failing to provide supervision. The Minister has referred to some consultants as "ghost doctors" (Mutizwa-Mangiza, 1996) while the Auditor General's report (1995) concluded that the performance appraisal system was "useless," as even the worst doctors were given very good reports. Junior doctors complained about being left to carry out serious surgical operations on their own, in some instances resulting in patients' avoidable deaths. The Auditor General's report supported the junior doctors in their complaints.

In response to public demands for more effective regulation of doctors and in a bid to forestall more stringent legislated medical audit, the medical fraternity voluntarily introduced medical/surgical audit in 1993/94. Basically, doctors of the same specialty meet at intervals. Interesting and unusual cases, and those that end in unexpected deaths, are presented to colleagues who comment and advise. The audit system is not perfect, as not all doctors are involved; bad cases of malpractice and incompetence can be left out; and consultants have no one to comment on their own performance due to shortage of consultants of the same specialty. Although junior doctors regard the process as one of "witch hunting" intended to embarrass them, the process does, to an extent, motivate them to be more careful.

Outside the above peer review system, Zimbabwean doctors do not comment on each other's work unless their opinion is asked for. As one junior doctor adamantly stated, "I would never report a colleague. That will create enemies and ruin someone's career" (Mutizwa-Mangiza, 1996: 182). In a bid to force health workers to watch their colleagues' performance, the government passed Statutory

Instrument 93 of 1993, which made it mandatory to report unethical or potentially harmful behaviour in fellow health workers.

The impact of hospital boards in informing health workers about their performance still has to be seen. The hospital boards of the major hospitals, which have been in existence for some time, have not been effective in influencing worker performance because of composition of the boards and because at the end of the day, they did not have the authority to discipline health workers. Health workers are civil servants and, until recently they could only be disciplined after following a long and cumbersome process and obtaining the approval of the Ministry of Public Service, Labour and Social Welfare. In most cases offenders are only cautioned. Obtaining a dismissal usually takes more than a year, during which the offender could still be working or on suspension with pay.

Most institutions and supervisors did not bother to initiate this frustrating process. The new management boards, which come into effect after decentralisation, may be effective in this respect if the disciplinary procedures are streamlined and their application is left entirely to local authorities, and if the board members have the political will to make them work. Things may change for the better when the role of the Public Service is significantly reduced and institutions have autonomy to carry out disciplinary measures.

Patients whom health workers attend to in government hospitals are not usually vocal because of the big social distance between themselves and health workers, especially doctors. Occasionally, patients or their relatives will complain in the national newspaper, write to the Health Professions Council or the MOH&CW, but this is only the tip of the iceberg. Sometimes communities hold public demonstrations in order to have a health worker transferred, or to stop a transfer where the worker is good at their work. Health workers explained that although patients sometimes complain, very often they express their gratitude for the service given.

On the whole, members of the public are increasingly registering their dissatisfaction with service providers although most are from the private health sector. The Medical Defence Union, a British medical insurance company, stopped providing insurance cover for Zimbabwean doctors because there were too many litigation cases. The perceived docile nature of most government patients has not encouraged doctors to be more accountable to their patients. One junior doctor stated that, "I am aware of the possibility of litigation with my private patients. I take lots of precautions to avoid mistakes and negligence. I always ask whether they are allergic to certain drugs." Thus, what should be standard medical practice is being reserved for private patients. The same doctor says of patients in government hospitals, "They are stupid and keep quiet even when things are terrible...that is why no one thinks patients will sue them" (Mutizwa-Mangiza, 1996:185). Junior doctors stated that they are also not too worried about being sued by patients in public hospitals, because the prosecution of public sector workers is always directed at the Ministry of Health and government pays any fine incurred rather than the health worker concerned.

In an effort to make health workers accountable to consumers, the MOH&CW developed a Patients' Rights Charter that essentially educates the public on the quality of service and behaviour they can expect in government facilities and how to lodge complaints. Health workers are unhappy with the document, which raises patients' expectations on the quality of service provided when, in fact, government hospitals characterised by shortages of staff and all types of material resources do not enable provision of such a service. In addition, health workers feel that the charter makes them targets of unfair criticism from the public and that it should also inform the public about the providers' rights.

The perception of most health workers is that the MOH&CW is harsh with other health workers and too lenient on doctors. MOH&CW officials contend that they would rather have doctors coming

sporadically to work than have none. Apparently, doctors threaten to resign when the MOH&CW attempts to discipline them. This has fostered a spirit of intransigence in doctors who know that they can get away with almost anything. Some managers pointed out that the patronage system has eroded discipline in government hospitals because the most intransigent ones usually have a powerful patron to protect them. Clearly the linkage between worker behaviour and the consequences of that behaviour is very weak.

The MOH&CW introduced a best worker award and a best institution award as a reward for good work and in order to encourage good supervision. While this is appreciated, some MOH&CW officials suggested that it would be better appreciated if there was a financial incentive attached to the awards.

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### **4.3 Worker Capability**

The general perception is that Zimbabwe trained health workers are very capable, as shown by the fact that they are in demand in other countries and excel in post-graduate examinations abroad. Health workers perceive themselves to have the skills to carry out their duties effectively. However, there have been demands to strengthen the behavioural science and professional ethics components in the basic training programs in order to improve their attitudes and sensitivity to patients. In the mid-1990s, the nursing directorate was running workshops on public relations for nurses, in a bid to improve their public relations skills and educate them on the notion of public accountability.

A Masters in Public Health programme offered by the University of Zimbabwe and sponsored by the MOH&CW is preparing health workers for senior management positions. Previously, doctors were just plunged into these very senior and responsible positions without any management training. In addition, the MOH&CW launched the management-strengthening programme discussed earlier.



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## 5. Communication Between the Ministry of Health and Health Workers

Senior MOH&CW officials concede that the first phase of the reform process was very badly managed in that workers were given very little information and not much attempt was made to consult them or sell the reforms. The MOH&CW officials were themselves caught unprepared; as one of them stated, “We were caught with our pants down.” The policy was adopted hurriedly due to pressure from donors. MOH&CW officials maintain that in the second phase, which started in 1995, serious attempts are being made to inform and consult health workers through their functional heads at head office and through the professional associations. Meetings and workshops have been held with senior and middle management who are expected to disseminate the information to those under them. In addition, articles on reform have been written in the newspapers and radio programmes have been scheduled. The MOH&CW also produces an in-house quarterly magazine, *Lifelines* in which topical issues are articulated and to which health workers can contribute.

However, in interviews, senior nursing personnel allege that the policy of decentralisation has not been clearly articulated and that, basically, they have been marginalised, if not ignored outright, in the policy formulation and planning process. Although middle and senior health managers have attended meetings in which the health reforms have been articulated, most feel the full implications of decentralisation are not clear even to the architects of the policy, and they find it difficult to support it. The President of the Zimbabwe Nurses Association, which had not been formally given the reform document, wrote to the Minister of Health to,

express the Nurses’ shock and concern at the manner you have handled the health sector reforms. It was a shock to learn that the document was to be put before parliament before nurses have had the opportunity to make comments on it. The nurses want to know why they are not being consulted on this...  
(ZINA President’s letter, 6/9/95).

In interviews, non-managerial health workers were not clear about what the reforms entail and their likely impact on themselves. Some stated that they did not see themselves staying in the public sector for much longer and did not bother to understand the reforms. In 1994, the Zimbabwe Medical Association (ZIMA) complained bitterly about the lack of consultation by the MOH&CW and even wrote to the country’s president about it. More recently, ZIMA has complained about the proliferation of privately owned clinics run by nurses. By July 1997, there were 48 registered clinics and nursing homes and many awaiting registration. Strong appeals to government about the illegality of nurses diagnosing patients and prescribing drugs have met with a strong rebuttal from ZINA, which argues that nurses are only carrying out those functions in private clinics which they normally carry out in most of the country’s government health institutions in the absence of doctors. Nurses, who are able to charge lower fees than doctors, are giving doctors stiff competition in the provision of antenatal care, post-natal care, terminal care and the management of chronic diseases. The MOH&CW is now working out the areas of competence for nurses that will satisfy doctors but not stifle the entrepreneurial spirit of the nurses.

There has been no outright opposition to the reforms themselves but there is apprehension especially concerning the nature of the health service after decentralisation. The main change that has occurred in response to reforms is the serious attempt by the MOH&CW to inform health workers in the second phase of the reforms. Another compromise on the part of government is the delay in implementing the performance-related salary, bonus, and promotion in response to the 1996 strikes by all civil servants, health workers among them. The government has also appointed a Health Commission after calls mostly from health workers. The findings of the Commission are likely to be very important for the future of the health reforms.

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## 6. Assessment of the Impact of Reforms on Health Worker Motivation

As pointed out earlier, the health reforms in the Zimbabwean context are an application of Economic Structural Adjustment Programme (ESAP) requirements to the health sector. The perception of Zimbabweans, health workers included, is that ESAP is the source of their economic problems. In reality, Zimbabwe was experiencing a serious economic crisis, and salaries and the standard of living had been declining for quite some time before the adoption of ESAP. However, the control of public spending and the removal of subsidies, which are some of the conditionalities of ESAP significantly reduced the buying power of salaries and plunged many below the poverty line. The ensuing economic hardships have made preoccupation with earning additional income an almost universal activity for most Zimbabweans. Many health workers either practise privately or engage in activities that are totally unrelated to their professions, sometimes turning their workplaces into mini-markets. As one consultant observed,

Before the reforms, when I entered a ward, nurses asked about the condition of their patients or some such work-related issues, but now when I come into the ward they tell me they are selling vegetables, doilies or goods from South Africa (Mutizwa-Mangiza, 1996: 215).

This preoccupation with earning additional income is affecting the workers ability to give their best in government hospitals as, for example, doctors seek opportunities to sneak out during working hours to practise privately. The Minister of Health complained that a supervisor preoccupied with improving their sales in the work place cannot be very effective. Part-time private practice is no longer for the “ethically weak” or the “politically uncommitted” as it was perceived before the reforms.

Liberalisation of the private health sector, a feature of the reforms, has promoted unethical behaviour by health workers. Interns, who are supposed to be working in supervised environments, are treating private patients on their own and, even though they may be competent, the patients do not know of their unregistered status. All interns interviewed admitted that they practised privately and asked, “Everyone does it. Otherwise how would we survive?” (Mutizwa-Mangiza, 1996 :214). Often, these doctors work privately during government working hours, thus cheating their employer but, more importantly, neglecting the patients in government institutions. Some doctors explicitly stated that they do the minimum in government institutions in order to create time for local work. While admitting that the practice is unethical, one junior doctor argued that, “Self-preservation is the first principle of nature. We have to live!” (Mutizwa-Mangiza, 1996:180). One senior registrar pointed out,

Total patient care is no longer there for both junior and senior doctors because you will starve. Patient care has therefore been compromised.

Another common and disturbing ploy is that a doctor on duty only sees a few patients in a long queue of waiting patients and as he/she leaves, either he/she or the nurses, advise the rest to go to his/her private clinic for attention. This is very unfair for the patients as they will have spent a lot of time waiting and paid money for treatment. MOH&CW officials claim that stealing of resources, such as drugs and equipment, from government institutions has become worse with the proliferation of private clinics. Some consultants treat their patients at the government’s expense and others advise

patients in government institutions that certain procedures can only be carried out in their own private clinics, a ploy to increase their own clientele. The MOH&CW has been trying with difficulty, to develop sessional contracts that will enable government to pay consultants for actual time spent in government institutions.

The Director of Nursing and other managers claim that rates of absenteeism and absconding from government institutions have risen while looking for alternative employment has become a serious preoccupation for many nurses who are very dissatisfied with government employment. Senior MOH&CW officials complain that much performance in government hospitals is half-hearted and yet the same people work diligently in private health institutions during their own time, sometimes even on the same day.

The rate of attrition from government institutions is another reliable indicator of serious dissatisfaction among health workers: there are 2000 vacancies nationwide for nurses; Kariba Hospital, which should have a staff compliment of 50, only has 16; Matebeleland South has 50% of its posts filled, and 65% of medical posts outside the major cities are held by expatriate doctors (Herald, 18/7/98). The Minister of Health admitted that,

We are operating under very difficult conditions and morale among health workers is very low... as a result of the poor facilities...some nursing staff are opting to go into the private sector where conditions of service are better (Herald, 18/7/98).

Most of the nurses who are leaving are the highly qualified and experienced ones, many of whom are going to other countries such as the United States, Britain, Saudi Arabia, South Africa, and Botswana, in pursuit of better remuneration and working environments. In May to August 1998, top MOH&CW officials recruited Tanzanian nurses and doctors in order to alleviate the desperate shortage of health personnel. In October, the Tanzanians refused to take up the positions because the Zimbabwe dollar had fallen from US\$1 to Z\$15 in May to US\$1 to Z\$30 in September, thus cutting the agreed salaries by 50% in real terms.

Both the public and health management believe that health workers, particularly nurses, are now more rude than before. One Herald reporter heard a nurse telling a patient who had asked for attention, "I am not your personal nurse" and in another instance, "I do not work for a thank you only!" (ZINA, 6/2/97). Health service users also perceive the health workers as uncaring and abusive because of disgruntlement with working conditions (Mutizwa-Mangiza, 1997). The health workers behaviour has also been attributed to an excessive workload and the stress arising from working with many dying patients. One junior sister working in a maternity ward at Harare Hospital admitted that the workload is so stressful that she can very well imagine being rude to patients and relatives. In a similar vein, one doctor commented thus, "I provide minimum care when dumped in the Casualty Department on my own" (Mutizwa-Mangiza, 1996: 168).

The Director of Nursing stated that nurses, including trainees, are handling several HIV/AIDS related deaths everyday, currently estimated at 700 per week country-wide. About 80% of patients in medical wards have AIDS-related illnesses, many with unpleasant sores on their skeletal bodies. In addition, they need a lot of attention, such as changing linen every few minutes. To make matters worse, some of their own colleagues are dying of the disease. The work itself is stressful, unenjoyable, and clearly not motivating, except for those with religious commitment.

Health workers have become much more militant in their demands for better remuneration and have stayed on industrial action for much longer periods than before. In 1994, doctors stayed on strike

for over four weeks and nurses stayed away from work for over eight weeks in 1996. Previously, they would go back after promises that their grievances would be addressed later, or when they were threatened with sacking, but this does not intimidate them any more.

It is difficult to choose one aspect of the health reforms that has had or is likely to have the most impact on health worker motivation, primarily because most of them have not been implemented yet. It is also difficult to isolate the effects of health reforms from those of ESAP and the harsh economic environment in general. Decentralisation may, in the short run, have the greatest negative impact on health worker motivation since health workers are already anxious about it. In addition, it has the potential, as pointed out earlier, of negatively affecting remuneration, job security, interpersonal relations, supervision, and promoting patrimonialism.

Liberalisation of the private health sector has had a significant negative impact on health worker behaviour. It is quite conceivable that even without liberalisation, health workers would have left their duties to work privately during working hours in any case, given the present economic environment. The delay in instituting regulatory mechanisms in the private health sector may partly account for the rampant indiscipline of government health workers. Effective regulation of the private health sector also requires political will, which has been lacking to date.

### **6.1.1 Socio-cultural Factors**

There are a number of socio-cultural factors which have the potential of negatively influencing health workers' attitudes and behaviour at work. The issue of patronage has emerged as an important theme that has the potential of negatively affecting health worker behaviour under decentralisation, regulation of health workers and possibly the administration of performance-related remuneration. The fact that loyalty to one's kin is of more primary value than professional ethics and efficient achievement of public goals has rendered regulatory structures in the public sector dysfunctional. This trend has been attributed to inadequate assimilation of rational-legal bureaucratic principles or the public sector ethos. Those in senior political and administrative positions often facilitate contravention of laid down procedures by their kin, thereby not only setting a bad precedent but also undermining the authority of those in charge.

The almost universal African practice of looking after the extended family has increased the economic hardship for many health workers and motivated them to engage in additional economic generating activities or leave the health sector in search of better salaries. This is compounded by the long held belief among Zimbabweans that good education is rewarded with a well paying job, high social status and other frills to show for it. This has made it difficult for most to accept the declining salaries and standard of living. One junior doctor clearly stated,

Look, society expects us to have a house and a car. I can't buy a house and I can't buy a car. I feel that sitting in an emergency car (an estate car used as public vehicle which is always overloaded with some people sitting in the boot) with my patients is humiliating. Sometimes when I am about to go and sit in the boot, my patients will tell me to sit in a proper seat and they sit in the boot (Mutizwa-Mangiza, 1996: 197).

The respect and high esteem with which doctors are regarded in the Zimbabwean society prohibits accountable behaviour. A disgruntled doctor who is working under all sorts of constraints and regarding himself/herself as economically deprived is not likely to show much respect to those

separated from them by a large social, economic, and information gap, particularly if he or she knows that they are not likely to complain or sue.

### **6.1.2 The Phasing of Reforms and Their Impact on Health Worker Motivation**

From the above discussion, it is clear that the first phase of the reforms was implemented rather suddenly due to pressure from donors and, consequently, health workers were caught unaware. Generally, the reform process has been implemented through an incremental approach because of political caution, but also because the momentum is generated by donors rather than by local leaders, most of whom are not quite convinced of the efficacy of the proposed health reform. Contracting out of health services and decentralisation have been delayed due to the government's fear of losing votes in the last elections. Most of the workers providing ancillary services are strong supporters of the ruling party. Decentralisation, which promises to change the nature of the health sector in Zimbabwe is, to date, being approached very carefully. MOH&CW officials complain about the lack of political support for the reform process in general and decentralisation in particular. They attribute this to the uncertainty of the implications of the process and a general fear that the health sector may collapse as a result. The lack of public support for the reform programme by the political leaders has forced MOH&CW officials to go very slowly. In their own defence, the MOH&CW officials maintain that the health system is working well and there is no need to rush the process, and that instead, different aspects should be implemented as opportunities present themselves. They refuse to put a timetable to the implementation process and maintain that other African countries had to do things quickly because their health systems had collapsed, which is not the case with Zimbabwe. The lack of clear articulation of the reform process has caused a lot of apprehension among health workers, in some instances leading to resignations from government service. The government has delayed implementing regulation of the private health sector because of fear of opposition by health workers.

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# 7. Conclusions

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## 7.1 Lessons Learnt

One of the most important lessons learnt from the Zimbabwean experience is that in this context remuneration is the single most important factor influencing health worker behaviour at present. The economic environment is so harsh that meeting basic needs is a struggle for most health workers. Even when these are met, financial rewards continue to be an important factor influencing the behaviour of most. Health workers who have left the MOH&CW maintain that the main reason for doing so is better remuneration. Many junior and middle level doctors who would not work in the rural hospitals in Zimbabwe work at rural hospitals in South Africa because of much higher financial rewards. Experienced nurses and doctors are leaving secure jobs in MOH&CW and going to work for nursing agencies in the United States and Britain. Cultural factors, such as the extended family, make it necessary for Zimbabweans to focus more on money than other issues. Taking into account the high inflation rate, it seems unlikely that the workers' need for higher remuneration will be fulfilled in the near future. This may mean that the MOH&CW will continue to experience high rates of turnover, strikes and other such behaviours. Factors such as job security, the work itself, training and advancement opportunities, supervision and recognition, even if met, will not improve worker motivation as long as the remuneration is perceived to be unsatisfactory.

Health institutions and professions are based on rational-legal principles, but the behaviour of most of the health workers is underpinned by pre-industrial cultural values, such as valuing kinship over public interest. This gives rise to patrimonialism and other behaviours which are incompatible with professionalism as perceived from an Anglo-American perspective.

The dominance of the doctors in the Ministry of Health and Child Welfare is a cause of intra-professional rivalry and poor morale among other health workers and is inimical to team spirit which is essential to effective health care delivery. The Ministry needs to open the top positions to the most qualified, competent and experienced health cadres rather than reserving them for doctors only. Most of the expatriate doctors appointed to senior positions at district level are less experienced than other cadres and have a high turnover rate which is disruptive to the efficient provision of health services.

The final lesson is that successful implementation of reforms requires much more time for planning, informing, and consulting health workers and mobilising political support than was available in the Zimbabwean context. The successful and timely implementation of reforms requires political commitment and that has not been evident in Zimbabwe to date, possibly because the reforms were seen as an outside imposition. It is also necessary that the reforms are planned in their entirety before implementation because some aspects of the reforms can have a negative impact on health care delivery. For example, health workers should have been allowed to work privately after the instruments for regulating the private health sector were in place. Similarly, the government should have cut some of the departments/ministries and retrenched personnel in order to reduce public spending. This would have enabled the government to pay higher salaries for remaining civil servants, health workers included.

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## **7.2 Areas for Further Investigation**

One important area that needs to be researched on is that of identifying the type of employment contract which can motivate government-employed consultants to carry out their duties effectively while at the same time enabling them to work privately.

There is also a need to examine the existing regulatory structures in both public and private health institutions in order to see how they can be better applied to reduce the high level of indiscipline among health workers that is currently disrupting effective health care delivery.

Finally, there is a need to investigate how some traditional, or pre-industrial, values incompatible with “professional” health worker behaviour could be taken into account within the context of health reforms.

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