



Understanding health worker incentives in post-crisis settings: lessons from health worker in-depth interviews and life histories in Zimbabwe

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Understanding health worker incentives in post-crisis settings: lessons from health worker in-depth interviews and life histories in Zimbabwe

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ReBUILD is working for improved access effective health care for the poor and reduced health cost burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality research on health systems financing and human resources for health, and working to promote use of this evidence in policy and practice.

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- Biomedical Research and Training Institute, Zimbabwe

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Cover picture: Nursing staff from surrounding clinics come to support their colleagues at Holme Eden Clinic, Zimbabwe. Photo courtesy of World Bank

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral treatment
CSSD	Central Steam Sterilising Department
EHP	Environmental Health Practitioner
EPI	Expanded Programme on Immunization
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSB	Health Service Board
HTF	Health Transition Fund
IDI	In-depth Interview
KIIs	Key Informant Interviews
MoF	Ministry of Finance
MoHCC	Ministry of Health and Child Care
MoHCW	Ministry of Health and Child Welfare
MRCZ	Medical Research council of Zimbabwe
NAC	National Aids Council
NIHFA	National Integrated Health Facility Assessment
PCN	Primary Care Nurse
PMD	Provincial Medical Director
RCZ	Research Council of Zimbabwe
RDC	Rural District Council
RGN	Registered General Nurse
SMO	Senior Medical Officer

SCN	State Certified Nurse
TB	Tuberculosis
WHO	World Health Organization

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Executive Summary

Introduction

The decade-long economic, social and political crisis in Zimbabwe continues to affect health service delivery in the post crisis period. The availability of human resources for health (HRH) in the right numbers, at the right time and place, with the appropriate skills mix and willing to stay in their jobs is a critical aspect of health service delivery. The crisis affected (HRH) and led to shortages and maldistribution of the workforce. Understanding health worker incentives in post crisis Zimbabwe is an important step towards reforming the once-effective health system.

Study aim and methods

The main goal of this project is to understand the post-crisis dynamics for HRH and ultimately how to reach and maintain incentive environments for health workers, in order to support access to affordable, appropriate and equitable health services. This report focused on the results of in-depth interviews with 35 health workers in three districts, using a life history tool for older health workers to understand the lived experiences of staff during and after the crisis. The majority of the respondents were female, with nurses and midwives the largest category.

Findings

The motivation to become a nurse or midwife was influenced by a combination of factors that included proximity to nursing schools alongside economic, socio-familial, and socio-psychological issues e.g. passion and calling. The study respondents reported that the motivators that influence nurses and midwives to join health professions have been eroded as a result of the crisis. The general perception among health workers was also that the quality of training has deteriorated during the crisis and continues to decline now.

It was very uncommon for nurses and midwives to be posted to municipal providers on initial posting because the regulations on initial posting do not allow it. On completion of training, almost all health cadres are deployed to rural areas for a period of 1 to 2 years. Life histories showed that most of the

health workers stayed at the initial posting for relatively short periods and moved to other posts by applying to the health service provider of their choice. Moving from public sector to municipality, rural district council or mission was always through application followed by interviews. Career choices were influenced by family considerations, desire to self-actualise, as a result of promotion and religious values.

According to participants, there were changes in work and livelihoods that led to health workers becoming demotivated. The most conspicuous change that occurred was the marked decline in the standard of living. Depressed salaries and dissatisfaction with working conditions became widespread. From 2004, all health workers were doing extra economic activities to sustain themselves. Selling different kinds of wares at the workplace was very prevalent during the crisis in the districts and sectors studied. Post-crisis, these practices subsided but continued. After 2009 and the adoption of the dollar, significant changes in working conditions occurred. Incentives were paid for workshops, and breakfast and lunch is being provided at the workplace. Vehicles for programmes like EPI (Expanded Programme on Immunization), under five monitoring and malaria are now available. General conditions of work have improved and are much better than they were during the crisis period, though still worse than pre-crisis.

Staff report an increased workload across all sectors due to reductions in staffing and the introduction of new programmes. Within the government and rural district council (RDC) sectors in particular, there is a sense of despondency, with participants describing a deterioration in status, pay, working conditions, standards and services over time. Staff in the mission sector are somewhat more motivated, despite facing resource constraints. There is a perception of increased politicisation in the selection of staff for jobs in the municipalities.

Staff awareness of public incentive policies is low. The rural area allowance is perceived to be too low to do its task of motivating staff to stay in rural areas. Pension was very important for all health workers in all the sectors and seemed the most important reason why the health workers remained in employment, even though some schemes (e.g. mission) have been eroded as a result of the crisis.

Poor funding for the health sector during and after the crisis has demoralised older health workers, who remembered a time when services functioned well. In the past, people felt their profession was a 'calling', but this desire to serve no longer holds any currency. In that regard, health workers are

now more concerned with monetary returns to their labour input, as they have seen a deterioration in their pay and conditions. The central role that rewards pay in contemporary health workers' motivation has meant highly skilled and experienced nurses and midwives have found more rewarding careers in the municipality facilities. Staff based in rural areas aspire to work in urban and peri-urban areas, with better conditions and greater opportunities to move into better posts. The rural health facilities which are predominantly public sector or rural district council-run are not well staffed, with some health facilities not having a single midwife.

The mission sector is generally viewed as providing better services by nurses working in the sector. The mission sector has the advantage of having more doctors, who are doing missionary work, seconded by sister churches within the same religious fraternity from overseas. This is motivating for nurses who can refer complicated cases to doctors, which does not happen in the public sector hospitals in rural areas due a lack of staff.

Conclusion

The motivation to join the health workforce is determined by individual level considerations which differ by gender. The most common motivating factors were calling, passion, desire to help people, proximity to health facilities, the nurses' uniform, family influence and role models. Economic factors including earning a salary on enrolment as a trainee and the guarantee of getting employed on completion were major attractions. The freezing of posts will make the guarantee of immediate employment after training obsolete as a motivating factor. The issue of retention is a very important aspect for health workers and should be well explained. Questions about the quality of nursing graduates have been raised because of the unavailability of experienced professionals to provide mentorship to the trainees and the selection processes for training places.

Recommendations

- The rural area allowance should be tailored to reflect the different degrees of remoteness— at present, the policy applies equally to areas close to conurbations as to genuinely remote areas, and is very limited in scale
- Retention mechanisms should be revised and made more equitable and transparent

- The issue of workloads in the public sector should be addressed by revising staffing structures and ensuring that new posts created are filled.
- Further instruments and resources (human and financial) should be provided to the Health Service Board (HSB) to enforce staffing standards in the municipal and rural district council so that optimal skill utilisation is achieved. This will enable the HSB to monitor the utilisation of available skills by ensuring that appropriate skills are deployed at the level of care they are needed most.
- The question of mentorship at training schools is critical and needs to be addressed urgently by ensuring that the health workers with the most experience are deployed at these hospitals where trainees do internships.
- The selection of trainee health professions should be transparent to ensure that only those deserving to be trained and with the right attributes are enrolled. This will ensure that the trainee- tutor ratio is adequate.
- The freezing of posts should be revisited so that a more future-oriented mechanism to reduce the budget ratio of salaries is found. Failure to recruit will lead to a worse problem of an aged health workforce with no replacement for mid-level skills.

Introduction

Background to the research

ReBUILD is a research programme concerned with health system development in post-conflict or post crisis countries and aims to develop lessons for governments on how to make or recreate and sustain equitable health systems. Understanding health worker incentives in post-conflict or post crisis-states is a component of the wider ReBUILD study undertaken specifically to explore the current incentive environments for key human resources for health (HRH) cadres in Zimbabwe.

Zimbabwe experienced a severe economic, social and political crisis that lasted close to a decade. The crisis exacted a debilitating effect on the entire health system, the ramifications of which continue to weigh down health service delivery in the post-crisis period. The health sector experienced sharp decreases in funding, deterioration of infrastructure, loss of experienced health professionals, drug shortages, increased burden of disease, and a high demand for services, which all inevitably led to a drastic decline in the quality of health services available for the population (MoHCW/HSB 2010, GoZ2009, NIHFA, 2012). The availability of human resources for health (HRH) in the right numbers, at the right time and place, with the appropriate skills mix and willing to stay in their jobs is a critical aspect of health service delivery. The crisis affected HRH and led to serious attrition across the entire health sector. There has been no profound improvement in HRH attraction and retention despite significant progress in resolving some of the causal factors of the high attrition of HRH in the immediate post-crisis period.

The main goal of this project is to understand the post-conflict dynamics for HRH and ultimately how to reach and maintain incentive environments for them to support access to affordable, appropriate and equitable health services. We used in-depth interviews and a life histories approach, to learn what selected HRH cadres thought about a number of issues related to incentives and retention.

Objectives of the study

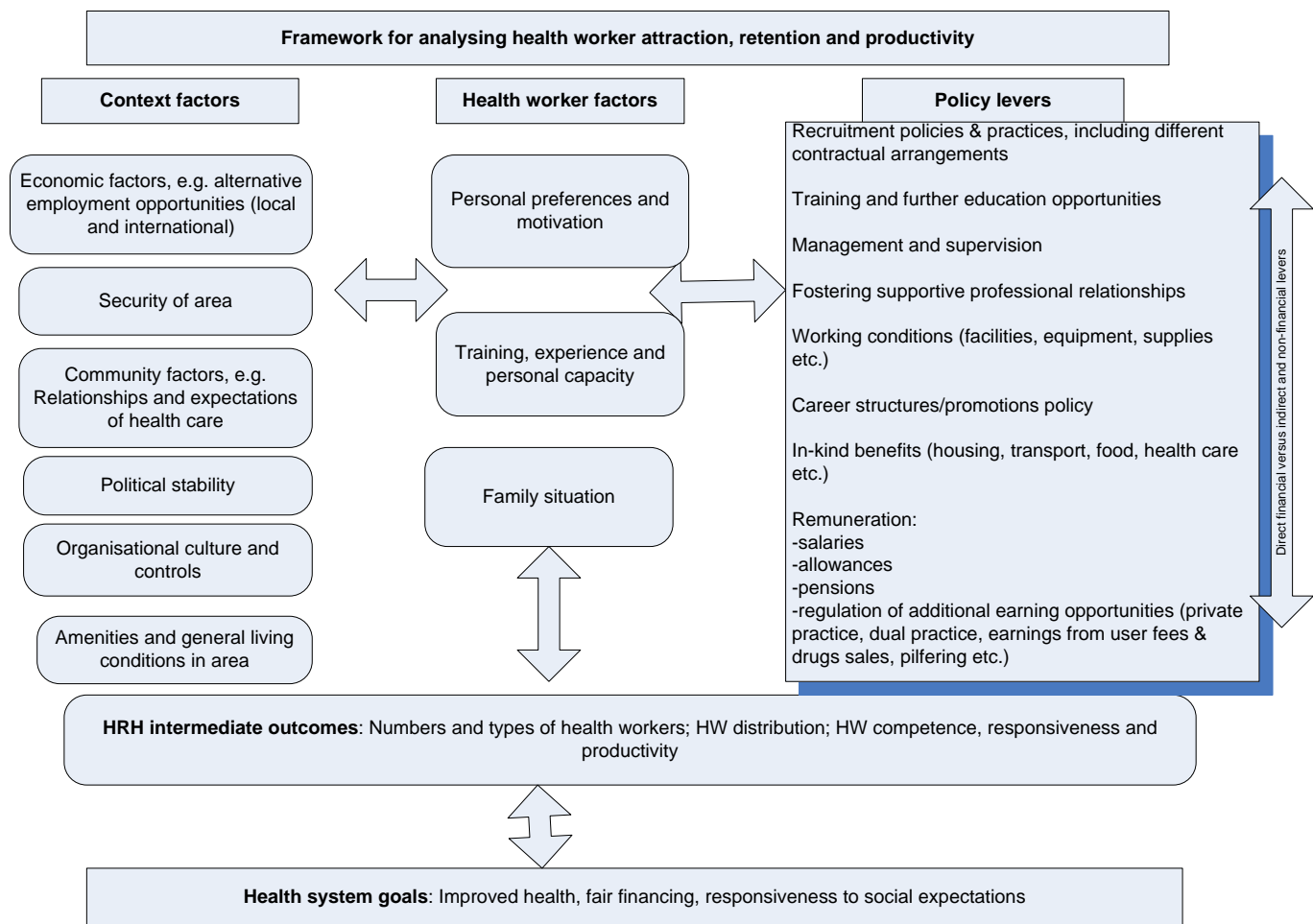
To explore the experiences of health workers in Zimbabwe, including their motivation to join, their career choices, their experience of crisis and perceptions of public policies in the different sectors.

Research methods

This report presents and analyses data from health workers' in-depth interviews (IDIs) and life histories. The study was cross-sectional and retrospective in design, focusing on the difference between key categories of health staff employed in different sectors of Zimbabwe's health system in three districts. The life histories and IDIs were complementary to key informant interviews (KIIs) and a survey with health workers.

Conceptual framework

Our conceptual framework highlights the interconnectedness and dynamic relationships among various factors that have a potential to impact on attraction, retention and performance of HRH in a given context [Witter et al. 2011]. The contextual factors, health worker factors and the policy levers interact in particular ways to produce both intended and unintended outcomes that impact on health systems. A further assumption we make is that past experiences influence present expectations and behaviours (health worker factors) while external factors (context factors) also influence developments in relation to expectations and behaviour. The analysis attempts to describe the interconnectedness and dynamic relationships among the three critical factors, context factors, health worker factors and policy levers. Relevant themes have been developed to analyse the data and assist in demonstrating the interconnectedness and dynamic relationships of these three factors.



Tool development

We developed the life history and IDI tools using a collaborative approach. We produced a generic topic guide which was then adapted to the local contextual situation in Zimbabwe and then refined after pre-testing. The life history guide and the IDI guide covered the following areas:

- How they became health workers
- Their career paths since becoming health workers and any influencing factors either during or after the crisis
- What motivates/discourages them to work in public facilities
- The challenges they have faced throughout their careers and how they have coped both during and after the crisis

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- Their career aspirations
- Their knowledge and perceptions of incentive policies during and after the crisis
- Their personal experience and the role of gender, age and family responsibilities in making decisions during and after the crisis.

The life history component involved asking participants to draw a lifeline with significant events in their lives including schooling, family, training and career. These were used as an aide for the in-depth discussion.

Study sites and site selection

The study was conducted in two out of twelve administrative provinces. The two provinces were selected because they host diverse health care employers from which comparative analyses of distribution, attraction, retention and performance of HRH across the spectrum of health care employers could be made. Three districts were then purposively selected from the two provinces and the selection criteria was the availability of diverse healthcare providers that essentially included municipality and or rural district council, private for profit, church or mission providers and the public sector. One wholly urban district with a diverse spectrum of health institutions representative of the various tiers of the health system was selected, a second district with both urban and rural sectors was selected and a third district which was wholly rural was also selected to make up the three study areas. The selection of the study sites was informed by the broad objective of comparing inter-provincial, intra-provincial and inter-sectoral variations among health workers with regard to experiences and perceptions on incentive environments and their effect on HRH retention.

Sample size and sampling methodology

Doctors, nurses, midwives, environmental health practitioners and clinical officers were identified as key participants for the study. The participants were purposively selected to get a spread across the cadres, districts and sectors. It was envisaged that a total of 36 life histories and IDIs would be conducted, with health workers in the three study sites covering the four different sub sectors of the health system in Zimbabwe, government, municipality, mission and private for profit and not for profit (Table

1). In district 1, five life histories were conducted while three were conducted in districts 2 and 3. The rationale behind the difference was the different proportions of health workers across the three districts.

Out of the planned 36 life histories and IDI interviews, 35 were conducted as shown in table 2. The gender distribution reflects the feminine composition of the health system in so far as the nursing and midwifery roles are concerned.

Although we sought to interview health workers with long service to get as much data as possible on the pre-crisis and post crisis dynamic, we did not exclude those who had been employed after the crisis, as few health workers were remaining from the pre-crisis period. The older health workers who had been in service pre- and during-crisis also filled in a lifeline. There were 12 staff who had who had served for this length of time.

Table 1. Planned sample life history and in depth interviews

Study area	Employer	No of cadre to be sampled
District 1	Government	Doctors: 1 Nurses: 1 Midwives: 1
	Municipality	Clinical officers: 1 Nurses: 1 Midwives Environmental officers: 1
	Mission	Doctors: 1 Nurses: 1 Midwives: 1

	Private for Profit	Doctors 1 Clinical Officers Nurses 1 Midwives 1
Total		12
District 2	Government	Doctors: 1 Nurses: 1 Midwives: 1
	Municipality	Clinical officers: 1 Nurses: 1 Environmental officers: 1
	Mission	Doctors: 1 Nurses: 1 Midwives: 1
	Private for Profit	Doctors 1 Clinical Officers Nurses 1 Midwives 1
Total		12
District 3	Government	Doctors: 1 Nurses: 1 Midwives: 1
	RDC	Clinical officers: 1 Nurses: 1 Midwives Environmental officers: 1
	Mission	Doctors: 1 Nurses: 1 Midwives: 1
	Private for Profit	Doctors 1

		Clinical Officers Nurses 1 Midwives 1
Total		12

Fieldwork

The life history and IDI guides were pretested in January 2013, in a district that was not one of the districts where the study was conducted. Fieldwork in the study sites was conducted in district 1 from 5 – 22 February 2013, and in district 2 and 3 from 12 - 26 May 2013.

Data collection and analysis

The life history and IDIs were conducted face to face with older health workers. The interviews were conducted in offices at health institutions. Confidentiality was assured throughout the data collection process. The lead researcher and an assistant conducted all interviews.

Recordings and written notes of the in-depth interviews and life histories were transcribed in Microsoft Word. A coding framework was developed based on themes and sub-themes. Data was analysed using a framework approach (Ritchie and Spencer, 1994). Framework analysis is an iterative approach with the following stages: familiarisation, listening to audio recordings, reading field notes, coding and identifying key themes, merging themes, searching for key findings, finding associations, and providing explanations for the results (Ritchie et al, 2003 pg. 212).

Audio recordings were transcribed verbatim so that original quotes were not lost. The audio recordings were compared with notes taken during interviews to fill in any gaps in information that could have been left out or miss-recorded during the interview. The interviews were then filed using identifiers such as district, type of facility, cadre and gender. Transcripts were read several times during familiarisation and recurring themes were identified. Findings were then synthesised across the main themes, noting patterns and differences across the sub-groups. In the Zimbabwean context, nurses and midwives are categorised as nurses, therefore, we analyse them as one group here.

Research ethics

The Biomedical Research and Training Institute Institutional Review Board reviewed the study in June 2012 before submission to the national ethics body. Ethical permission was obtained from, the Medical Research Council of Zimbabwe (MRCZ) on 2 January 2013. Further review was done by the Research Council of Zimbabwe (RCZ) as is required with all research involving collaboration with international partners. The study was also approved by the Liverpool School of Tropical Medicine. Informed consent was obtained from all study participants before the interview (see annexe for consent forms). An information leaflet with information about the study was provided prior to the research to all participants through the head of the institutions they were affiliated to. A consent form which participants were asked to read before the interview also provided further information. The participant then made a decision to participate voluntarily and affixed their signature on to two consent forms, one of which was retained by the participant and the other by the researcher/interviewer. The participants were assured that the whole process would uphold the highest standards of confidentiality, that their participation would be anonymised and that that all research records would be kept securely.

Research limitations and challenges

Carrying out the IDIs and life histories was very challenging, particularly in a situation where participants were still smarting from the effects of the crisis. The raising of hope that things were now going to get better was very palpable among participants. The other challenge was that we could not get the optimum number of participants as planned.

The private sector was difficult to access as managers refused to allow participation, hence why we could not carry out the life history and IDI interviews in this sector in all three districts. In district one the mission sector refused to participate and this also affected the final number of life histories and IDI carried out. There was apparent suspicion and negative perceptions on the part of the mission sector in district 1 with one senior ward manager remarking:

The challenges facing the health sector are well documented and well known and it is really difficult to understand why one would want to carry out a study. The MoHCW has district,

provincial quarterly reports which outline all the issues that you want to find out from your study or what you say the study is concerned with from your information sheet. Why waste money, use that money to improve the health sector, it's a lot of money and we know it will get into your pockets as consultants

There was an imbalance in the representation of cadres interviewed as a result of denied access. Doctors from the municipality did not participate, and in the mission and private sector only one doctor from each took part. Environmental health professionals were also not well represented because in urban areas, the government hospitals and in rural areas the mission sector do not have these posts. In district two and three we failed to interview the planned sample because the nurses were not available, either because they were not in post or that those in post had joined the health sector after 2007. Senior doctors were sceptical that the research would yield any change in policies like all other previous research:

Whoever was sponsoring the study knows the truth about what is affecting the health sector and therefore it was folly to expect them (SMOs, Specialists, Specialist consultants) to have time for mundane questions instead of getting on with work.

Findings

35 health workers were interviewed in the three districts, 17 in district 1, 9 in district 2 and 8 in district 3. The characteristics of the participants are shown in table 2 below. 3 were male and 32 were female, and their age range was 31-65. A total of 2 doctors, 21 midwives, 9 nurses and 3 EHPs were interviewed. 9 came from the government sector, 14 from the municipality, 2 from the Rural District Councils (RDCs), 6 from the mission and 4 from the private sector (in fact these were public staff working within the private facilities). These distributions reflect staffing distribution on the ground, the selection criteria and their willingness to be interviewed.

12 health workers who had worked in the health sector before, during and after the crisis in the four sub-sectors (categorised as older health workers) took part in the life history exercise.

Table 2 Actual sample of interviews

Study area	Employer	No of cadre sampled	No of Cadres interviewed		
			F	M	Total
District 1	Government	Doctors:	0	0	0
		Nurses:	0	0	0
		Midwives:	3	0	3
	Municipality	Clinical officers	0	0	0
		Nurses:	0	0	0
		Midwives	2	0	2
		Environmental officers:	7	0	7
	Mission	Doctors:	0	0	0
		Nurses:	0	0	0
		Midwives:	0	0	0
Private for Profit	Doctors	1	0	1	
	Nurses	1	0	1	
	Midwives	1	0	1	
Total			16	1	17
District 2	Government	Doctors:	0	0	0
		Nurses:	2	0	2
		Midwives:	1	0	1
	Municipality	Nurses:	1	0	1
		Midwife	1	0	1
		Environmental Health Professionals:	1	0	1
	Mission	Doctors:	1	0	0
		Nurses:	1	0	0
Midwives:		1	0	0	

	Private for Profit	Nurses	0	0	0
Total			9	0	9
District 3	Government	Doctors:	0	0	0
		Nurses:	0	0	0
		Midwives:	2	1	0
	RDC	Clinical officers:	0	0	0
		Nurses:	0	0	0
		Midwives	1	1	2
		Environmental officers:	0	0	0
			0	0	0
	Mission	Doctors:	0	0	0
		Nurses:	1	0	1
Midwives:		2	0	2	
Private for Profit	Doctors	0	0	0	
	Clinical Officers	0	0	0	
	Nurses	1	0	1	
	Midwives	0	0	0	
Total			7	2	9
Overall total			32	3	35

Motivation to join the health profession

Nurses and midwives identified calling and passion, personal life circumstances, economic needs, attraction of status, -security and working conditions, family influences, proximity to services, and lack of alternatives as reasons that motivated them to join the health profession.

Personal calling

Most health workers mentioned their passion to help and the calling to the profession. This was more common among the female nurses who were the majority of the interviewees (because the nursing field is largely female-dominated in Zimbabwe).

I wanted to be a nurse because I have a passion for it (IDI 004 Female nurse Private for profit Medical Centre district 1)

I grew up liking the nursing profession; I had a heart to help people so I went to school of nursing from 1981 up to 1985. (IDI 015 female nurse Municipal clinic district 2)

It was a calling from God; I just wanted to help people when I was young. When I was in form 4 I helped a certain mother to give birth to her child, I grew up a quite person so I saw that nursing is the right profession for me (IDI 006 female nurse Provincial hospital district 2)

I became a nurse because I used to like what nurses used to do and I admired their job, I was also encouraged by my grandfather who was employed at Mashoko Mission Hospital to join the nursing field (IDI 022 male nurse RDC health centre District 3)

The motivation to become environmental health workers for two of the EHPs working for the municipality was not based on any prior knowledge of the benefits of the profession. The participants responded to an advert in newspapers. The participants did not even have an idea of what the job entailed or how well paying it was or how socially esteemed it was. The participants simply responded to available posts and this was possible because they resided in an urban setting with ready access to newspapers.

...born in 1962 in a rural setting. Started sub A in 1969 and repeated grade 1 in 1970 and did primary up until 1976. My father was a primary school head so I used to follow him wherever he went. Did secondary education i.e. form 1 to 4 from 1977 to 1980. I joined Ministry of

Education as Temporary Teacher in 1981. Still based in the rural area, I taught up to 1983. The political situation was not conducive to staying in the rural areas in 1983, we then came to town. That is when I came across a MoHCW advert and I applied and was shortlisted and attended an interview at PMD's offices. I was successful and was selected to go and train at Domboshawa Training Centre in April/May 1983. I trained for three years and in 1986 (IDI 002male EHP Head Office District 1)

Personal and life circumstances

We interviewed a male nurse who volunteered to be a medic during the independence war and later formalised the training at the end of the war

I came to work as a nurse because I volunteered to work in the health field during the war; I had a passion for the job (IDI 021 male nurse Public sector rural hospital District 3)

Lack of alternatives

One of the participants joined the environmental health profession¹ as a fall-back position that enable her provide services related to health, having failed to academically qualify for medicine.

I wanted to do medicine but my points were not sufficient so I enrolled to do Environmental Health Sciences (IDI 008 female EHP Municipal head office).

There was one participant who joined the medical field because they were not accepted into the career that they really wanted

¹ Environmental health practitioners do preventive work, health promotion, inspections of public utilities and vector control for endemic diseases like malaria. There are two categories of cadres the Environmental Health Technician and the Environmental health officer

I wanted to be a police woman but I was short changed by my height. I grew up in a police camp and I used to admire the B-car. I joined nursing as it had a name in the community (IDI 010 Female Matron Central Hospital District 1)

Economic factors

The nature of nurse training, particularly access to monetary allowances at enrolment and the fact that after training one was assured of a posting, were very strong motivations for individuals' decisions to become health workers. The fact that nurse training came with an automatic government grant and no tuition fees made it quite attractive to prospective nurses. The following account on the struggle to choose a career path in the nursing field is indicative of the strength of the economic determinants:

I was born in 1952 on 28 January. Went to secondary school at St Bernard's Mission and finished form 4 in 1971. [I] went to Mtshabezi in 1972 to train as a teacher, trained for two years. We were paying fees and as a person who was coming from a poor family, I was not managing to pay the fees... dropped out of training after getting a place to train as a nurse at Fatima mission. (IDI 001 female nurse at Municipal Hospital)

When my father died I had no one to send me to school. I then chose to go to Munene for nursing training from 1972 to 1975. During nurse training we used to get allowances and this sustained me and my other siblings. I worked at Mpilo from 1976 to 1982 and then joined council in 1982 (IDI 007 female nurse Municipal Clinic District 1).

I did nursing after doing standard six and also did Midwifery. I did nursing at St Theresa in Chirumanzi in 1970. I then did 'O' level after I started working. I did not have money to do secondary school education so the better option was to do nursing (IDI 009 female nurse Municipal Clinic District 1)

Self-sufficiency during training and the guarantee of getting employed on completion of training were strong motivators that were mentioned. Most parents encouraged their siblings to train for medical professions so that they would quickly start contributing to extended family economic sustenance, at the same time as advancing their own career development.

I did nursing after doing standard six and also did Midwifery. I did nursing at St Theresa in Chirumanzu in 1970. I then did 'O' level after I started working. ...I did not have money to do secondary school education so the better option was to do nursing to help with the education of our other siblings (IDI 009 female nurse Municipal Clinic District 1)

I liked nursing because if someone is trained he/she is given a place to work unlike where by someone has to struggle looking for a job. We were given uniforms and accommodation for free and we also used to get our salaries the first month you are enrolled, I became a nurse because I wanted to help people. (IDI 013 female nurse Provincial hospital District 2)

Attraction of status

Admiration of the nursing profession, especially the esteemed status of nurses within society, the uniform, and the life-saving aspect of the medical field influenced the decision to become health workers for a number of participants.

[I] went for SCN training in 1969 at Bonda Mission. Back then, jobs that were common were nursing and teaching. I was interested in nursing that is the reason why I joined the nursing field. What was interesting was getting into a theatre and seeing a patient being operated (IDI 003 female nurse municipal clinic district 1):

[I]Finished "O" level in 1980 and in 1981 I started nursing training. I was attracted by the white uniform, cap and the shoes. I wanted to be a bank teller but could not get a divisional number and I then applied for nursing (IDI 004 female nurse Municipal Clinic District 1).

... I used to adore nurses in their white uniforms since I was young so I came to train as a nurse in 1995 up to May 1999 (IDI 012 female nurse, Central Hospital District 1).

Family influences

Some nurses mentioned having a liking for the nursing profession but also indicated that role models in their families further influenced this.

I just wanted to be a nurse from way back; my sister was also a nurse so I admired her so much (IDI 020 female nurse [Sister in charge] Rural hospital District 3)

My father wanted me to be a nurse so he motivated me and sought a place for me at a nursing school in Zambia though I had learnt [studied] in Zimbabwe. I worked for a few years in Zambia before coming back to Zimbabwe (IDI 005 female nurse Municipal Clinic District 1)

My sister was a nurse and she inspired me to be a nurse. I did not have money to do secondary school education so the better option was to do nursing to help with the education of our other siblings (IDI 009 female nurse Municipal Clinic District 1)

Proximity to training schools and hospitals

Other participants stated that they joined the medical field because they grew up within an area with a mission hospital and a nurse training school. The close interaction with nurses garnered a sense of admiration which shaped future career options. Proximity to the hospital increased interaction with nurses and the admiration for their profession. Several participants grew up, attended school and trained around these mission posts and on completion worked at these posts:

I grew up in this area and I came to church here when I was very young so I was inspired by the way sisters and nurses attend to patients. (IDI019 female nurse mission Hospital District 3)

I grew up at a mission so I admired what the sisters were doing helping patients when I was at school (IDI 013 female nurse Provincial hospital District 2)

Training experiences

Participants recounted training experiences from the beginning of their career as health workers. The government funds all training in the health sector. Most of the nurses we interviewed had been in the health profession for more than ten years life history guide targeted health workers who had been in the health sector before, during and after the crisis. Most of these older health workers had to undergo further training to upgrade their qualifications. Upgrading from SCN was a yearlong training programme.².

I first trained as an SCN at Munene Mission hospital. I enjoyed working in a hospital especially in preparation for further training in a big hospital. I then trained as an RGN at Mpilo (IDI 001 female Nurse Municipal clinic District 1).

...want to continue working here. I wish I could do something but these extended families restrict me. Wanted to do upgrading but with responsibilities I have its impossible (IDI002 Municipal Clinic District 1 female nurse)

1982-85 trained as SCN at Munene Mission, SCN midwifery in 1987-88 at Ndanga hospital, 1992-93 RGN conversion training at Kwekwe hospital, 1995 worked at Ndanga, that same year went to Gwelo hospital for midwifery conversion and went back to Ndanga. In 2000 was promoted to Sister in Charge and worked at Mwenezi as SIC and I did my first degree in Nursing Science with Zimbabwe Open University (ZOU) in 2005 it was self-sponsored, from

² Beginning in 1997 there was a change in regulations and the State certified nurse (SCN) qualification became redundant and was replaced by the Diploma in Nursing, whose holder is what is termed a registered general nurse (RGN). Environmental health professionals started working after having attained the certificate in environmental health. Environmental health professionals started working after having attained the certificate in environmental health. At around the same time the certificate in environmental health also became redundant and was replaced by the diploma in environmental health, and those willing to attain the diploma were supported by the ministry.

2004 I was at Ndanga and I was promoted to SIC up to 2012, in 2007 I did Nursing Administration at Parirenyatwa. In 2012 I came to this facility as Matron Grade 3 (IDI 015 Mission hospital District 2 female nurse)

Nurses who did not upgrade were stigmatised and asked to work in departments that were less glamorous. Hence in large central hospitals it is rare to find nurses with SCN qualifications. This discrimination is inconsistent with government policy, as the qualification is still recognised and registrable.

I like my job very much but the issue of resources is still a challenge, it makes our job difficult because we cannot work up to our maximum. Workload is a big challenge because of shortage of human and material resources. This is a central hospital and most of our patients are referred to us by clinics and are usually of a complicated nature. We require RGNs in this institution to deal with these complicated nurses. That is why you find very few SCNs here we only have one who is responsible for the CSSD. (IDI 012 Central Hospital District 1 female matron).

The nurses who had been trained outside of Zimbabwe had their papers verified by the health professions council to ensure that their qualification was 'comparable' with the local ones. Furthermore, they had to take an examination and those that were found wanting had to go for additional training.

During the war I trained as Medical Assistant in Romania in 1978 up to 1979. After the war in 1980 we wrote a test from the Health Professions council in order to get a certificate here in Zimbabwe. In 1981 I registered as a medical assistant and worked at Gutu rural hospital from 1982-1984. IDI 021 male nurse Public sector rural hospital District 3)

The burden of upgrading was solely felt in terms of having to study as all financial costs to upgrade were borne by the Ministry of Health and Child Welfare (MoHCW). However with regards to studying towards ordinary level, which was a prerequisite for eligibility for upgrading, cadres had to fund themselves. Once they acquired O-levels they were given first priority at the nursing schools to

upgrade. Older nurses with SCN certificates reported that the financial burden of studying for ordinary levels was enormous as they were already looking after dependents who also wanted school fees. It was not possible economically to work towards upgrading.

[I] want to continue working here. I wish I could do something but these extended families restrict me. Wanted to do upgrading but with responsibilities I have its impossible. (IDI 002 female nurse Municipal Clinic District 1)

Perceptions on quality of training

Quality of training was reported to have been the biggest casualty of the crisis. The general perception among health workers was that the quality of training has deteriorated and continues to decline. Factors that were reported to be the cause of this were interrelated and included: heavy workload, resignation of senior health workers from the health facilities hosting training schools, inadequate supply of sundries and resources. Each of these made the whole environment in which health workers were trained unsuitable to produce a well-trained cadre. Lecturer shortages, poor selection of students (a process that had become highly manipulated, meaning that some of the students enrolled were unsuitable), unavailability resources in the wards (so students could not get a practical understanding of what they were learning) and, a low standard of mentorship available at health worker training institutes, were reported. The poor mentorship resulted from the massive resignation by senior health workers to other more rewarding providers or to greener pastures in the diaspora. In the rural areas the issue that seems to worry health workers was the unavailability of resources.

Supervision of juniors, largely depends on maturity, we had a lot of senior people and we learnt from them as trainee nurses. These days a junior quickly rises to a senior post due to staff shortages. Senior nurses have gone to greener pastures leading to the current situation where the mentors also need mentorship. (IDI 010 female Matron Central Hospital District 1)

I feel very worried at times because of the conditions in the hospital, they have deteriorated greatly, there are no cups, soap, clothes, and bed linen is not good for the patients the sheets are no longer being ironed. We are doing our best but the conditions are bad. As a training school what does this say to the trainees... (IDI 010 female Matron Central Hospital District 1)

At times you feel very bad when you look at the patients, especially their food. The food is very bad patients can go for a week or so with only sadza and vegetables and black tea with nothing. Sometimes patients complain about being hungry especially the diabetic ones it is a pity. Even as workers the conditions are also bad for us to help the patients you do not feel like you are doing the real nursing we used to do. Now bring in the nurses we are training the bedside nursing skills are about ensuring that patient conditions are conducive... but they see this deprivation of patients and when they graduate surely these things will affect their professional performance. (IDI 021 male nurse Public sector rural hospital District 3)

There is no transparency in the recruitment of students and workers. You will see a husband, wife and children working at the same place. You cannot control behaviour of people with power, they corrupt the situation and they are difficult to manage and supervise.... There are so many students compared to the mentors, hence supervision is a problem resulting in so much truancy around. (IDI 010 female Matron Central Hospital District 1)

Movements between jobs

Health workers reported that deployment and posting were individual choices or a result of promotion or economic and social considerations. During the pre-independence era, posting was not automatic after initial training. All graduates, particularly nurses and environmental health professionals, had to job hunt. Health workers who joined the health sector before independence thus got jobs in any sector including municipalities but after centralisation of deployment, on completion of training, health workers were deployed to rural areas and hence it was typical that initial posting for such cadres would always be in the RDC, mission or government sector. Economic and social considerations, included transferring to be close to one's family, were also factored in.

I did my training in Gweru in 1989 then I worked at Mwenezi, I started working as an office orderly, then trained as SCN in 1989 in and I came here at Masvingo General Hospital in 1991. After working at Mwenezi I then moved to Masvingo because my family was in Masvingo. The transfer was easy: I had once worked at Takavarasha and Nehanda so they know me very well (IDI 013 Provincial hospital District 2 Female nurse)

Most of the health workers stayed at the initial posting for periods ranging from 1 year or more. After two years it seems most of the health workers moved to other posts of their choices by just applying to the health service provider of their choice. It was very uncommon for nurses to be posted to municipal providers on initial posting because the regulations on initial posting do not allow it. On completion, all health cadres are deployed to rural areas for a period of 1 to 2 years. Hence all participants interviewed had at some point worked for government, mission and rural district council.

Moving from public sector to municipality, rural district council or mission was always through application followed by interviews. Those that were successful were then engaged in the position. The health service posting regulations also provide for secondment although among participants we never encountered a case.

I applied to the municipality for a job, was interviewed and got the job in 1990 and ever since I have been a nurse in the municipality and I will retire from here in a year's time (IDI 003 Nurse Municipal clinic District 1 Female nurse).

Life history data shows that the municipality providers and rural district council requested applications from prospective health workers with certain specifications, short listed and then interviewed them to recruit the best candidate. Most nurses applied for jobs in provider sectors where they could access certain economic advantages. One of the nurses applied to join City Health in district 2 where she has worked ever since. She has worked there for 26 years.

...after qualifying I worked at Morgenster hen at City Health since 1988... The job was advertised in the newspaper then I applied and I was called for an interview and I passed the interview. ...I'm staying here till retirement... I'm getting a very good salary, housing allowance, professional allowance, midwifery allowance, water allowance, transport allowance... other employers do not pay these (IDI 015 female Nurse Municipal clinic district 2).

Managers, who ask cadres to transfer to selected facilities, also influence choices of jobs. This is probably due to a sudden departure of a health worker from a particular facility. The choice of jobs was also influenced by the desire by a to be closer to their home area. For this particular health worker the decision to transfer closer to home coincides with the deepening of the economic crisis and could be viewed as a calculated decision to cope with the demands to save money

On the 8th of April 1991 I was employed by the Bikita Rural Hospital stationed at Negovana clinic and I worked there up to 1996. That same year in 1996 I went for RGN upgrading at Morgenster Hospital for one year. In 1997 I went to Pfupajena clinic and I was transferred back to Negovana up to 2002. I moved to Gangare at the end of 2002 and from Gangare I made a request to be transferred to Murwira close to my home/family. (IDI 022 male nurse RDC health centre District 3)

This mission sector matron applied for her role because she belonged to the same faith as the mission. The trajectory of posting also indicates that she moved to different jobs because of improved qualifications and promotion.

The job was advertised in the newspaper, I applied and I was called for an interview and I qualified for the post and they wanted someone who belonged to their church so since I belonged to that church I got the job...1982-85 trained as SCN at [name of institution]... ... In 2012 I came to current facility as Matron Grade 3. (IDI 017 female nurse Mission hospital District 2)

The participant also indicated that the professional choices she made over the years were largely influenced by an urge to self-actualise:

I like the high self-esteem that I get from my job, you have to be up to date with current things I like my job I always learn more. I have applied to the school of medicine to do Masters in Maternal Child Health, I just like the job even though the money is very little, I have always liked to teach students especially when they write their exams I feel very honoured that they appreciate what I do - teaching them. I taught Administration and for the first time the school won a gold and bronze medal nationwide. However there are some things I do not like, now that the job is taxing or demanding, I do not like people who lie and people expect a lot from me. I also do not like people who compromise the welfare of patients. There is too much of Administration work at the mission and I'm involved in all things like pharmacy, accounts unlike in the government where you will be responsible for one department (IDI 017 female nurse Mission hospital District 2)

Two of the nurses reported that they had trained at the mission hospital and then were invited to remain at the facility after qualification.

... after qualifying I worked at Morgenster mission I did all my upgrading here and went for midwifery this is the only hospital that I have worked at except the locum work have done at the provincial hospital and the other private hospital. (IDI008 female nurse Mission hospital district 2).

Some cadres made more than six moves in their career, with a few having stayed in the same post and sector and some moving within a particular sector to different facilities. Patterns of health worker postings extracted from life history charts show that highest number of postings was 8 and the lowest was 1. Transfers were high in government and RDC, each with cadres who had moved eight times. The least postings were reported in the mission and private sector by two female cadres both having single postings. The cadre in the mission sector had been in the same post for 30 years while the one in the private sector was doing locum work for three months at the private hospital at the time of the interview, but had been in her government post for three years (see Table 3).

Table 3 Patterns of postings from life history charts

IDI No.	District	Sector of facility were cadre was interviewed	Gender	Age	Profession	No. of Postings	No. of postings in Govt	No. of postings in Municipality	No. of postings in Mission	Length of service (Career)	Length of Govt Service	No. of post within 3yrs after Basic
1	1	Municipality	Female	61	SCN	3.0	2.0	1.0	0.0	35.1	4.0	1.0
2	1	Municipality	Male	50	EHO	2.0	1.0	1.0	0.0	26.6	3.5	1.0
3	1	Municipality	Female	62	SCNM	4.0	0.0	2.0	0.0	39.9	0.0	2.0
4	1	Private	Female	50	RGN	2.0	2.0	0.0	0.0	7.1	0.0	1.0
5	1	Private	Female	30	RGN	1.0	1.0	0.0	0.0	3.6	3.6	1.0
6	2	Government	Female	64	SCM	6.0	5.0	0.0	1.0	33.5	30.5	1.0
7	2	Municipality	Male	48	RGN	5.0	1.0	0.0	3.0	19.5	8.5	1.0
8	2	Mission	Female	63	RGN	5.0	1.0	0.0	4.0	30.5	2.2	1.0
10	3	Mission	Female	55	SCM	1.0	0.0	0.0	1.0	31.5	0.0	1.0
11	3	Government	Female	57	RGN	8.0	4.0	3.0	1.0	30.0	20.0	3.0
12	3	RDC	Male	44	RGN	8.0	8.0	7.0	1.0	21.5	21.5	1.0

Health workers working for Rural District Council facilities reported that the government administers them, but the RDC transfers and moves health workers. The reason for this is that the RDC sees itself as responsible for all social amenities in the district and intervenes in moving staff as a means to ensure that no health facility closes its doors when there are unplanned vacancies caused by death or retirement.

I was initially posted to Negovana clinic [RDC]. In 1997 I was transferred to Pfupajena clinic [RDC] and I was transferred back to Negovana up to 2002. I was moved to Gangare at the end of 2002 and from Gangare I made a request to be transferred to Murwira close to my home/family. All the transfers were requested by the RDC because of sudden vacancies at the clinics as a result of death of the cadres in the first instance and the rest were to replace cadres who had retired. The only transfer that I initiated was when I moved to Murwira and I will retire from here. (IDI 022 male nurse RDC health centre District 3)

In the past staff accommodation was a pull factor in rural areas, as health workers were attracted by the subsidised accommodation. However, with the continued expansion of the health sector, more

departments and new programmes brought in additional staff who needed accommodation. This has led to various initiatives by facility managers to improvise. Strategies adopted included using other rooms that were not meant to accommodate staff for this purpose. There are some health workers who think that conditions in rural areas were better than in urban areas.

Staff accommodation is also a problem some nurses are staying in boys hostels and there are no cooking facilities and some building have deteriorated but they cannot be renovated because of lack of funds. . (IDI 017 female nurse Mission hospital District 2)

Rural health centres are the most advantaged health facilities in terms of staff than in towns. Many of their basic needs are for free e.g. accommodation, transport etc. (IDI 014 Male nurse Government provincial hospital district 2)

The choices of jobs among EHPs shows that as they gain experience in the various public sector departments they become much sought after by the municipalities. Despite reaching seniority in the public sector, they may be motivated to shift to the municipal sector for financial reasons, despite the post having less seniority.

I finished college and started at the Ministry of Health. I was an Environmental health officer at the Ministry of Health for two years, Lectured at [name of college] for 6 years, tutored at [name of college] before joining the Council in 2009. I wanted to do medicine but my points were not sufficient so I enrolled to do Environmental Health Sciences (IDI 008 female EHP Municipal head office).

All the cadres were content to end their careers with their current employer at their current facility. Reasons for not wanting to change jobs were that they were about to retire, they had homes nearby, they could manage their income generating projects and they had children who were teenagers. Although not mentioned, the level of promotion that they had attained also made moving to other jobs unattractive. An analysis of the professional profiles collected during the interviews shows that most matrons and sisters in charge across the sectors were not planning to change jobs within or across sectors.

I'm staying here waiting for my pension because I'm now old [53 years old]... I have a poultry project and I rear 2000 chicks at a time and I'm also into buying and selling from South Africa and Tanzania. (IDI 020 female nurse [Sister in charge] rural hospital in district three)

...Am stuck here as my children are teenagers [52 years old] (IDI 010 female Matron Central Hospital District 1)

I do not plan to go anywhere. I am happy in Zimbabwe. I have a brother who is in the United Kingdom who has called me but I am content here. If you change jobs then you will not get a good pension. I want to retire whilst in council employment [52 years old]. (IDI 006 female nurse Municipal Clinic district 1).

I'm staying here till I resign; I'm planning to do a project so that it will help me when I retire. [55 years of age](IDI 015 female nurse Municipal clinic District 2)

Pension was very important for all health workers in all the sectors and seemed the most important reason why the health workers remained in employment. Transient shocks similar to the crisis were seen as passing phases that could be quite destabilizing in the short term but one could be rewarded for a lifetime of commitment on retirement. The crisis disrupted numerous benefit schemes, including the pension schemes for mission hospitals which were being administered by a private insurance organisation. The differences in the mission sector pension scheme were not well understood by mission health workers. The introduction of dollarisation made mission workers realise that their pension scheme was different and that they were in fact all starting afresh to contribute to the mission sector pension scheme and that all that they had been contributed had been eroded as a result of the abandonment of the Zimbabwe dollar currency.

The government must take mission hospital and make them government hospitals, as mission hospital we used not to have fixed pay dates and we do not have pensions we need them also (IDI 019 female nurse mission hospital District 3)

Experience of crisis and coping strategies

According to participants there were changes in work and livelihoods contexts that demotivated health workers. The most conspicuous change that occurred was the marked decline in the standard of life. Depressed salaries and dissatisfaction with working conditions became wide spread. From 2004, all health workers were beginning to do extra economic activities to be able to sustain themselves. The practice of selling a variety of wares at the workplace was very prevalent during the crisis in all the districts and sectors studied. Although most said they had stalls where they employed some people to sell on their behalf some informants pointed out that cases of vending at the work place used to occur.

Government salaries and working conditions should be improved. The government workers do not earn enough money. Some HRH do variety commercial activities to supplement their income. Some of them had become cross border trading and they bring back items of clothing which they sell on credit to staff (IDI 001 female nurse municipal clinic district 1).

I'm in the business of buying and selling cattle, usually I buy when they are auctions and I sell the cattle to general people or those with butcheries. I just send people or my wife to do the buying because most of the time I will be busy at work (IDI016 Male nurse district 2)

We also saw an increase of health workers who would go to the diamond fields to hawk wares among the diggers where they could get foreign currency as the diamond fields attracted diamond traders from different foreign countries (IDI 017 female nurse Mission hospital district 3).

The practice has subsided in the post-crisis era and although those that do it now do it discretely. Unavailability of money in banks was another characteristic of the crisis, especially between 2005 and 2006, which meant that from payday, health workers would fail to come to work as they sat outside banks waiting for their chance to get their money. It would take several days for health workers to withdraw their salaries and this affected operations at health facilities. The switch to United States dollars improved cash availability post-crisis and the absenteeism related to pay days came to an end.

Money was very little during the crisis period so the introduction of the US\$ came as a relief. During the crisis there was widespread selling at the work place fuelled by the acute shortage of cash. Withdrawing one's salary from the bank had become a demanding exercise requiring a lot of time (IDI 018 female nurse mission hospital District 3)

Access to earned money was difficult during the crisis years which led to high absenteeism during pay days. Because most banks had a limit to what one could withdraw it meant that one had to visit the bank on several days to get enough to buy household needs. (IDI 013 Female nurse Provincial Hospital district 2)

After 2009 and the adoption of the dollar significant changes in working conditions occurred. Incentives were paid for workshops, breakfast and lunch were provided at the workplace, and vehicles for programmes like EPI, under five monitoring and malaria became available. General conditions of work have improved and are much better than they were during the crisis period.

Work satisfaction and feelings about roles

Participants across the three districts were not satisfied with several aspects of their work. In district one, health workers pointed out that workloads had increased phenomenally. The increase in workload was linked to the introduction of new programmes. The new programmes come with registers that have to be completed on a monthly basis. National Aids Council (NAC) will want its registers for opportunistic infections and antiretroviral therapy (ART), and the MoHCC has several registers that are required. This is against a backdrop of low staffing levels. Nurses have to carry some of these registers home to do them overnight because the number of patients presenting at facilities is very high due to the burden of disease. In district one there is a serious problem in that the municipality facilities refer cases to the central hospital in the public sector if they discern that the illnesses are of a complex nature, bypassing the polyclinics.

New things are being introduced and it has changed the way we work. There are now a lot of registers e.g. TB, ANC, Immunisations etc. We are learning new knowledge but because of

shortage of staff we work overtime or even take registers home to complete the work. Work load has increased a lot (IDI 003 female nurse | Municipality clinic district 2).

There is acute shortage of human and material resources therefore we cannot deliver the way we are expected to deliver. We also face victimisation from other departments especially on the issue of resources. We shoulder a burden which is not ours because our seniors also tend to ignore some of the issues blaming the stores department of failing to buy the materials. However, these days we are used to these problems because there are not being solved (IDI 012 Public sector female nurse District 1)

Standards have deteriorated, we no longer have enough equipment and it is now old we are relying on donated equipment so if the materials break no one will repair it, like for example we have an ECG machine is no longer working no one can repair it. . (IDI 016 female nurse mission hospital District 2)

The huge numbers of patients with serious conditions have to be cared for by disaffected doctors and by nurses who are less experienced and working with inadequate equipment. This situation is compounded by a deteriorating standard of service delivery, which managers attribute to the politicisation of selection processes for training and recruitment.

There is no transparency in the recruitment of students and workers. You will see a husband, wife and children working at the same place. You cannot control behaviour of people with power, they corrupt the situation and they are difficult to manage and supervise. (IDI 010 female matron central government hospital district 1)

The same problem exists in district two and three where municipalities and other providers refer complicated cases to the mission sector facilities. The mission sector facilities \ had better facilities and more doctors. At the time the research was done, the two mission facilities in the sample had 6 doctors. The proper referral chain would have been from municipality to provincial hospital, which is closer to the municipality. However patients opted to be referred to the mission hospital 22km away

in district two. Some even opted to be referred to the mission hospital in district three which is 108km away. This leads to disproportionate workloads for underresourced mission hospitals.

District three, a largely rural one, has health facilities that belong to the RDC and health workers assert that the workload is huge. There are a lot of new activities that require the completion of several records which is also compounded by more patients who now present at the clinics.

Our job is good but we have problems with workload, it is too much for us here because we are short staffed. Nurse patient ratio has not changed since 1980 but the population is increasing daily, we have so many registers and we end up working at night in order to finish the work (IDI 022 male nurse RDC health centre District 3)

EHPs have varying responsibilities in the public sector, and municipalities. In the private sector there are no EHPs as these are normally in the urban area. The responsibility to ensure that environmental issues are managed is the realm of the municipalities. In the mission sector there are no EHP posts and all EHPS in the mission sector are seconded from the public sector to the mission hospital. When we asked about workloads in the municipality sector in both district one and two there were varied answers. In district one the EHP interviewed had job responsibilities of supervising all cemeteries and crematoria activities (cremation of bodies).

It's challenging as I always work with people who are mourning. It needs inner strength as mourners are not 100% mentally fit (IDI 002 male EHP Municipal health department).

Another participant on how they feel about their job stated that:

It is more challenging because I actually go into the field and do more hands on work. I like it because you interact with the public. I like the fact that I manage myself and I am flexible to set my own schedule and set my own goals to be achieved in a set time (IDI female EHP 008 Municipal health department).

There is also the challenge related to conditions of service which the participant felt needed attention. The issues relating to exposure to harm during cremation and continuous training on modern systems of cremation were making the job less desirable:

There is need for danger allowance especially taking into account what happens during cremation of bodies, we are using one cremator and it takes council time to repair it such that it is prone to explosion. It is also risky to use gas tanks, the tanks can explode (IDI 002 male EHP Municipal health department).

The other participant had responsibilities related to inspection of all public buildings that included shops, supermarkets churches, schools, night clubs and beer halls.

EHPs in the public sector do health promotion, which involves health education with particular focus on prevention of diseases, control of parasites and waste disposal to avoid multiplication of parasites that cause diseases. They also inspect public buildings including shops, supermarkets churches, schools, night clubs and beer halls.

The EHPs in the municipality do not mention workloads as a problem but those in the public sector mention the workload as heavy. They argue that the geographical areas that they have to provide services are huge and they travel long distances. They say the motorcycles that have been provided ease the challenges but a more far reaching solution could be the appointment of all unfilled posts and increase in the establishment posts.

Work satisfaction was related to how health workers felt about their job. Most nurses in the municipality facilities were content. While the work load was huge, they had four doctors to deal with complicated illnesses, sufficient drugs and ambulances that were readily available for those requiring emergency transfers to central hospitals.

Conditions are much better in municipal health departments. We have a reliable fleet of ambulances which are ready ferry patients to the next level of care. We also have doctors

who come to deal with complicated cases one day a week. We also have the biggest infectious diseases hospital in the city. These days as you know TB is a serious problem and we always refer severe cases to that hospital (IDI 006 female nurse Municipal Clinic district 1).

They also noted that most patients that visit facilities are urban-based and on medical aid. When referrals are made some of the patients on medical insurance are eligible for emergency transfers to referral hospitals by private ambulances like MARS and EMRAS. They feel their role as health care workers is fine and rewarding because they can provide proper assistance to all patients who present with ailments. There was a slight deviation among matrons we interviewed who felt that from a supervision perspective they were inundated with trivial work arising from mistakes made by the younger and more recently trained nurses, which then leads to them being asked to write numerous reports. They noted that the quality and skills level as well as the commitment of recent nursing graduates is unacceptably low. They observed that the municipality human resources system has been politicised and hence a lot of nurses are employed on political and partisan lines.

An administrator at one of the health facilities said:

During training, there was good quality nursing and work performance was in line with standard nursing. Time after independence, new cadres are not motivated by nursing care but by money. Hence in many cases the cadres cannot deliver, you can't supervise them (IDI 011 female Matron Central hospital district1).

Even cleanliness, they now leave it to general hands. There is now no more privacy, even training has a lot of loop holes. And when you ask third year students you are supervising, they do not know some simple things; think there is a lot of favouritism during enrolment... training has a lot of loop holes. And when you ask third year students you are supervising, they do not know some simple things; think there is a lot of favouritism during enrolment. (IDI 007 female Nurse Municipal clinic district 1)

These new cadres do not have manners; they do not respect their seniors. Give them work to do, they will say do it yourself. Even general spellings and also taking patient history is a problem. They deny even to rotate to do some duties, the juniors fight to do some simple duties. Some do not know how to do a simple Paracheck test for malaria, and in the end you doubt the passing and qualification (IDI007female Nurse Municipal clinic district 1)

The way of training nurses has changed, standards have gone down. Salaries have gone down because what we would achieve with pay before was more than now. Increase in-patients means people are not getting adequate nursing care. Maternity patients would be discharged after seven days even patients operated on but now they are quickly discharged (IDI 009 female nurse Municipal Clinic District 1)

Staff are not properly trained and groomed; they do not have patients at heart. They cannot do simple patient staging (grouping according to seriousness of illness), during our days you used to prove that you have qualities for you to be promoted. We used to know our patients by name, not now where they forge their work and they are very difficult to work with. Meetings with staff members are vital i.e. with different grades so that you manage well and find way forward (IDI 004 Municipal Clinic District 1).

The other challenge is the issue of space, we use one room for many different activities, we wish we had a mother's shelter it would have been better because some of the activities were going to be done in that room. When we started working there was no HIV testing, syphilis and TB screening. There was malaria testing only all those things are now there and we are doing them. It would have been easier for us if there was space to do the work and some increase in health workers (IDI 022 male nurse RDC health centre District 3)

Health workers in the public sector, particularly nurses, talked of gloom and disenchantment about their roles. One of the senior health workers who rose until she reached matron grade gave the following account:

When I joined the nursing profession twenty six years ago it was satisfying to be a nurse. Remuneration, was good, availability of resources was good. The hospital infrastructure was good and it felt good to be a nurse. This combination of good factors made nurses respectable in the community. In recent years all this has changed. The remuneration is so bad that nurses cannot afford decent accommodation. They have lost the respect that they used to have. They are disenchanting and difficult to work with. The dilapidated infrastructure and unavailability of resources makes one feel dejected. We feel hopeless as ambulances bring patients to the central hospital who require specialist help which we cannot deliver. We have become more of death traps. People have even said that once you are admitted at the central hospital you do not exit the way you came in. By this is meant that you are admitted through the casualty department and you exit through the mortuary department, dead in a coffin (IDI 010 female Matron Central Hospital District 1).

Public sector nurses were disaffected with the remuneration that they were getting. Experienced health workers were very unhappy with the salaries that they were getting and they also pointed out that the retention allowance like those being paid to selected health workers like the health transition fund (HTF) created management problems. There is evidence that the HTF implementation of the HTF was not preceded by adequate sensitisation on who would be eligible and why. A participant in the mission sector stated that the mission sector was not eligible for HTF

I am not happy, am not satisfied because of the salary and the conditions of service. A person in my post must have incentives e.g. car loan, i.e. incentives that make you comfortable (IDI 011 female matron, Central Hospital District 1)

I feel very bad about my job especially the money side of it, the standards have deteriorated greatly. The years before the crisis the conditions were better.. There was the introduction of the Health Transition Fund (HTF), this fund destroyed all the structures we used to have. It made junior nurses to get more money than us senior nurses, so it is difficult to supervise someone who is better paid than you. (IDI 014 Male nurse provincial government hospital District 2)

We have had of HTF an allowance that will support Maternity departments and FHC departments it has not been rolled out yet. But it is going to create problems for matrons especially with regards to moving cadres to help out in case of shortages. You will not get cooperation from the cadres who will not be included in the HTF in case of a situation where we want to help out in emergency (IDI 011 female matron, Central Hospital District 1)

There is retention allowance, HTF for midwives... Mission institutions are side-lined for example we are not getting HTF for midwives while other government institutions are getting it. (IDI 017 female nurse Mission hospital District 2)

In district two the nurses were not happy with a wide range of the conditions and terms, in the public sector. Rural Area allowance was reported to be too low with some of the deserving health workers saying it was so insignificant that they were not even aware of how much it was or whether it was being paid or not. The same applies to uniform allowances that were so low as to make no impact, meaning that uniforms were being bought from one's income which further impoverished health workers. The low uniform allowance was reported in all the sectors.

I feel very worried at times because of the conditions in the hospital, they have deteriorated greatly, there are no cups, soap, clothes, bed linen is not good for the patients, the bed sheets are no longer being ironed. We are doing our best but the conditions are bad. At times you feel very bad when you look at the patients, especially their food. The food is very bad: patients can go for a week or so with only sadza and vegetable (IDI023 female Public sector hospital district two).

I used to know about rural allowance but I do not know if it is still there. (IDI 016 female nurse mission hospital District 2)

I get a salary and that salary including allowances it adds up to \$450, there is transport allowance, housing allowance, uniform allowance and retention allowance from the donor though it has been reduced and it is not fixed. (IDI 022 male nurse RDC clinic district three)

*Housing is more important because transport and uniform is too small. It makes no change actually and to maintain high standards of smartness expected in the profession one has to spend more on uniforms than the allowance. **IDI 005 Female nurse Municipal clinic 1 district***

*I have a salary, housing allowance, uniform allowance \$15 per month, ... the uniform allowance is just not enough... getting a good uniform will cost much more than \$180 we get per year. This amount of \$15 cover the cost of laundry only not replacement of uniforms. **(IDI 019 female nurse mission hospital District 3)***

In district three the nurses were also not happy in the public and RDC sectors as these excerpts depict:

*The job is very challenging because some of the things we are improvising, there are many hardships. **(IDI 022 male nurse RDC clinic district three)***

*Workload is increasing; there is shortage of staff and material resources so we work over time at times **(IDI 020 female nurse (Sister in charge) rural hospital in district three)***

*Our job is good but we have problems with workload, it is too much for us here because we are short staffed. Nurse patient ratio has not changed since 1980 but the population is increasing daily, we have so many registers and we end up working at night in order to finish the work **(IDI 020 female nurse [Sister in charge] Rural hospital District 3)***

In the mission sector, interviews indicate that health workers are more concerned about remuneration, accommodation and shortages of equipment. However they feel happy about being nurses. This is probably because a lot of people in district two and three view the mission health facilities as more responsive and effective. This seems to make the nurses content and willing to stay in their posts, which are mostly in rural areas.

The number of patients coming here has increased we are a referral centre, the increase in number might be due to the good reputation that we have, Masvingo hospital used to refer

patients here because we used to have good doctors so that reputation is still there (IDI 019 female nurse mission hospital District 3)

Experience of changing public policies

Very few workers have knowledge about policies relating to deployment of health workers to rural areas. They were aware of those policies that affected their day-to-day operations especially those that relate to allowances and establishing staff at rural facilities. The most well known is the free maternal and child health policy which is difficult to implement because of inadequate resources during deliveries. There were quite a number of health workers who were aware of the rural allowance policy and these are cadres who had worked in rural areas before.

I don't know of any policy, as for me, I just prefer to work in the community where I grew up in. (ID 020 female nurse Rural hospital District 3)

I know of the rural allowance however, the rural allowance is too little, it is not attracting people to work in rural areas. It must be increased. (ID 021 male nurse Public sector rural hospital District 3)

What I know is that when there is a shortage here we are given nurses after their training but when the number is enough nurses are given to other clinics. PCN are the mostly deployed in rural areas. There are usually two trained nurses and one nurse aide in rural areas. I once worked at Nehanda in rural areas. (ID 013 Female nurse Provincial Hospital district 2)

Health workers in government, mission and RDCs reported that they were unhappy with the duty free importation facility for cars. They pointed out that it was being administered in a manner that left out cadres in rural areas.

Duty free for civil servants was once introduced and I was very happy because I managed to buy my car and because of that I will not leave my job. There must access to duty free

importation for every nurse so that we buy our cars and have easy transport and this will make everyone like to stay on the job (IDI020 female nurse [Sister in charge] Rural hospital District 3).

Am not happy, am not satisfied because of the salary and the conditions of service. A person in my post must have benefited from the long touted duty free importation of vehicles (IDI 011 female matron Central hospital District 1)

The opportunities to earn extra income were very limited. Doing locum work as a way to increase income was seen as not inclusive. The salaries should be increased and made more attractive although locum should still exist for health workers that want to follow this route.

The main challenges are shortage of resources, low salaries, low incentives and no access to locums....The government should use the money it uses to pay locums to pay salaries for more nurses though locums should continue as it cushions critical or urgent staff shortages. (IDI 011 female matron Central hospital District 1)

Administrators like matrons, sister in charge, nurses in charge and hospital administrators in the public sector were aware of some of the policies that changed with regards to HRH. In the municipality very few of the employees were aware of the policies on HRH as these do not apply to them. This is because much as government asserts that the municipalities are part of the public sector, it is evident that most policies, especially those relating to remuneration, performance management and promotion do not apply to municipality health workers.

Discussion

The study participants were predominantly female reflecting the nature of the health sector. The majority of the participants were nurses and midwives who constitute the biggest number in the health service.

The study identified key motivating factors that influenced decisions to join the health sector. Economic and personal calling were dominant reasons in most health worker accounts. The training experiences showed that the health sector is dynamic and that health workers were constantly required to upgrade. The contextual, individual factors and policy environment are important attributes that shape health worker experiences. The huge number of female health workers compared to males is a function of the dominant contextual view that females are better at providing care than males. The policy related to remuneration during training influenced decisions to become health workers for nurses across all sectors. This also applied to EHPs employed by the two sectors (government and municipality) that are mandated to employ EHPs (Public Health Act 1924). Individual factors that influenced the decision of some to take up a health profession were having a family member who was a health worker, a parent or guardian influencing the individual, or the need to take the job because it was the only one available featured in health worker accounts.

Some health workers were attracted by the nurses' uniform. Some cadres mentioned that they had done other jobs or preferred other jobs, that they failed to get, and eventually became nurses. Very few female cadres had joined the profession because of a lack of alternatives and most state that they have since discovered that they had a passion. Family pressure to join the profession and role models in the family also play critical roles in motivating individuals to join the health professions. The motivation to be a health worker differed by cadre and by gender. EHPs were motivated to join the profession by advertisements in newspapers calling for applications. Nurses and midwives identified calling, passion and the urge to help people. A key finding is that the male nurses and midwives interviewed became health workers as a second preference or by exigencies of the situation made some male participants take up nursing. A significant number of cadres, especially nurses and midwives were motivated to join the profession by growing up in close proximity with mission hospitals and the interaction with nurses and seeing the nurses in uniform were a great motivator.

Socioeconomic circumstances motivated people to become nurses and midwives especially because a stipend is paid when training for a job in the health sector. Economic security during training is a key motivating factor.

Related to the aspect of economic security is the guarantee of getting a job without fail on successful completion of training in the pre-crisis era for most health professions. This has however changed in the post crisis era as the notion of job security has been eroded as cadres have to search for work because of the job freeze (MoHCC, 2014; HSB 2012). Zimbabwe's health worker density is 1.23 per 1000 population, which is still far below the WHO standard (HSB 2010 (Chirwa et al 2014, MoHCW 2009). The freeze in place since 2010 poses strategic risks in so far as HRH supply over time is concerned. The attractiveness of the health sector lay in its ability to absorb graduates into jobs and the freeze surely has led to a dilution of this aspect as an attraction to the health professions. Vacancy rates for nurses and midwives had improved after the crisis to about 98% filled posts, according to MoHCC staff returns of 2014 (World Bank, 2015). The freeze will affect replacement of staff as they retire as there will be a void created for those years that recruitment has not been done.

Passion was another attribute mentioned widely as a motivating factor to join the health profession. This was mentioned most by nurses and midwives. Interviewees noted that the crisis has changed perceptions and the notion of passion has been replaced by the idea of monetary benefit. According to older health workers, the monetary rewards have overtaken passion as the *sine qua non* for joining the health sector in contemporary times. Recent studies assert that the reason why health workers migrate from their home countries is that they are dissatisfied with the remuneration and retention incentives (Martineau et al, 2004). Salaries were said to be low and irregular during the crisis. Health workers in Zimbabwe were unable to withdraw salaries due to widespread money shortages. This was so frustrating and contributed to huge disruptions to health provision as health workers absconded work or simply left their posts because they wanted to withdraw salaries from the bank. Failure to access salaries led health workers in the public sector to perceive themselves as an exploited group and stopped them turning up for work (GoZ 1999, HSB 2011, Chimbari, 2008, Mudyarabikwa, 2006, Dambisya et al, 2010).

In 2009, the introduction of the harmonised retention allowance improved health worker availability in the short term. However, around 2012 the reduction of the amount being paid for retention allowances was now demotivating health workers (HSB 2011). In 2012, the HTF was introduced and its modalities were not well understood by health workers. The HTF targets health workers in grades C5 and above across doctors (up to three per district) midwifery tutors "practising" midwives, critical

posts and other areas of support (Mudyara, 2015). These criteria of the HTF caused tension as those facilities not included are unhappy and face a lot of problems from health workers who feel they are being left out.

Health workers also value pensions or end of service payments. The health workers across the sectors who were 50 years and above reported that they were not going to consider moving from their current job because they did not want to jeopardise their end of year service awards. The mission sector health workers were not happy with the administration of their pensions and were eager to be included in the government pension system. Generous end of service payments have been adopted in Namibia as a long term strategy, to retain health workers among others, like subsidised house owning schemes and car ownership. Matching salaries and remuneration with those in the destination countries for migrating health workers is not attainable in low income countries (Martineau et al 2004).

Subsidised accommodation, which used to attract health workers to rural areas, is now one of the reasons that health workers shun posts in rural areas. Slow construction during the crisis and the government's increased burden caused by the taking over of mission hospitals, accommodation no longer matches the health workers at facilities (MoHCW 2009, Chirwa et al 2014; 2015[a] Chirwa, 2015[b]). Health workers bemoan the overcrowding and the intrusion of privacy due to sharing of accommodation, particularly in rural areas. The MoHCW (2009) National Health Strategic Plan (2009-2013) observes that the lack of accommodation has contributed to the inability to retain health professionals in most institutions.

Findings show that motivation is not a result of a single attribute but a combination of several attributes, (Franco et al, 1999). Health worker incentive initiatives require broad based frameworks that look at many aspects, like financial, and social (Lin et al, 2011). Extrinsic and intrinsic aspects of motivation are important. We notice that uniform allowances have been given little consideration in recent times yet this is very important for some health workers. Health workers are not satisfied with the monetary allowances that they get towards the purchase and maintenance of their uniforms. Yet this seems to be a very critical symbol of prestige that needs to be given special consideration by employers across the sectors. This was also found in ReBUILD interviews in Uganda and Sierra Leone (Namakula et al 2013, Wurie & Witter 2014).

Training experiences for nurses show that most nurses had to upgrade their qualifications due to changes in qualifications. The participants also did further training to acquire more advanced specialised skills in various areas. This was the case with other HRH we interviewed like the environmental health practitioners and is underlined by existing studies (Mapanga and Mapanga 2000, Zimbabwe Health Professions Council 1999). For nurses and environmental health practitioners the replacement of the certificate by the diploma meant that individuals had to acquire the diploma by undergoing completion courses which meant enrolling for an extra year to study the curriculum for the final year of the appropriate programme in one's field. Nurses who had acquired SCN and certificates in midwifery could not upgrade because they did not have ordinary level and due to their age and changes in curricula in high schools doing ordinary level was difficult. Hence such health workers were content with the SCN qualification. However, the fact that one's qualification was considered redundant is a demotivator and may lead to poor job performance. These changes reflect a wider trend to specialisation in the health professions (Zimbabwe Health Professions Council 1999).

These changes in qualification standards were geared towards improving the quality of the health workforce across all disciplines that are critical for primary health care. Training was dogged by poor selection of trainees due to interference by powerful individuals who imposed candidates for training who were not really motivated by the professional ethos. Poor staffing at training colleges for the health workforce meant inadequate tutorials and supervision for the students and this affected the quality of graduates. Unavailability of critical resources at facilities meant that internship, an integral component of training for most health worker training programmes, was ineffectual. Compounding this further was the disproportionate relationship between students requiring mentorship and available mentors, as most senior health workers with the requisite skills had left their posts (Sikhosana, 2005, Chikanda, 2010). During the years spanning the crisis there have been suggestions that graduates coming to join the workforce are not well trained and are unmanageable because of their links with powerful individuals.

After the initial posting some nurses move from one health facility to another either in pursuit of better conditions of work or closer to some desired amenities like schools for children.(Chimbari, 2008, Wheeler, 2010, Dieleman, 2010, Chirwa, 2014, Chirwa 2015[a], Chirwa, 2015[b]). Before the

introduction of the paid maternity leave, female health workers career profiles show constant job changes and those who graduated much later show less movement in the first three years of initial appointment. These health workers stayed at the initial posting for periods from one year or more then moved to the next facility through transfers. After two years most of the nurses moved to other posts of their choices by just applying to the health service provider of their choice. After application was submitted most applicants were called for interviews. Those that were successful were then engaged in the advertised position. On completion of training health workers are deployed to rural areas except for a few who may utilise the special consideration option to be deployed in urban areas.

Special considerations for initial deployment include marriage, disability or other reason that the secretary of health approves. When health workers complete their probation they areas are free to transfer (Public Service Regulations 2000). To enhance chances of getting jobs in better areas, health workers enrol for special courses that give leverage to be accepted for jobs. The more trained the health worker the more likely they are to leave for the better paying sectors and eventually the global market (Wheeler 2010).

Workloads were heavy for most health cadres and general working conditions were not attractive, although the retention allowance improved salaries in the post crisis period. This made working much better and was an attraction to other health workers particularly in the public sector, rural district council and mission sector who had suffered during the crisis. The mission sector attracts huge numbers of patients and this increases the workload immensely. Heavy workload is one of the key push factors for health workers to leave their jobs (Chikanda, 2010).

There was a general lack of knowledge about policies among health workers, including those related to retention allowances among health workers in the public, mission and rural district councils. The assertion that mission, municipality and RDC health workers are part of the public sector is not accurate as the cadres in these various sectors are administered differently. It is demonstrated in the findings that there are differences in a number of key HRH planning and management issues. The transfer processes differ markedly in RDC with the council having a lot on authority to move cadres from facility to facility. In the municipality the HRH are also restricted to municipal facilities and cannot be sent to work in the other two sectors.

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Conclusion

The motivation to join the profession was determined by individual level considerations which differed by gender. For female cadres the most common motivating factors were calling, passion, desire to help people, proximity to health facilities, uniform, family influence and role models. Male cadres joined the health professions due to lack of alternatives and or exigencies of situations which included responding to advertisements in the paper and volunteering to train as medics during the independence war. Economic factors including earning a salary on enrolment as a trainee in the health professions and the guarantee of getting employed on completion were major attractions. The freezing of posts makes the guarantee of immediate employment after training obsolete as a motivating factor.

Health workers in the public sector, mission and RDC are more disaffected than their counterparts in the municipality and hence there is movement from these unattractive providers to the more attractive providers. This harms the health delivery system as experienced health workers are concentrated in the municipality sector. This creates a vacuum in terms of mentors in the higher level facilities for trainees who are trained in these institutions. Questions about the quality of nursing graduates have begun to be raised because of unavailability of experienced professionals to provide mentorship to the trainees.

Recommendations

- The rural area allowance should be tailored to reflect the different degrees of remoteness— at present, the policy applies equally to areas close to conurbations as to genuinely remote areas, and is very limited in scale
- Retention mechanisms should be revised and made more equitable and transparent
- The issue of workloads in the public sector should be addressed by revising staffing structures and ensuring that new posts created are filled.

- Further instruments and resources (human and financial) should be provided to the Health Service Board (HSB) to enforce staffing standards in the municipal and rural district council so that optimal skill utilisation is achieved. This will enable the HSB to monitor the utilisation of available skills by ensuring that appropriate skills are deployed at the level of care they are needed most.
- The question of mentorship at training schools is critical and needs to be addressed urgently by ensuring that the health workers with the most experience are deployed at these hospitals where trainees do internships.
- The selection of trainee health professions should be transparent to ensure that only those deserving to be trained and with the right attributes are enrolled. This will ensure that the trainee- tutor ratio is adequate.

The freezing of posts should be revisited so that a more future-oriented mechanism to reduce the budget ratio of salaries is found. Failure to recruit will lead to a worse problem of an aged health workforce with no replacement for mid-level skills

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Annexes

A. Tools

1. Understanding health worker incentives in post crisis settings: Zimbabwe

In-depth Interview with health workers/Life history: Topic Guide

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

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

B. Note details of participant.

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

OPEN-ENDED QUESTIONS TO PROVOKE DISCUSSION:

1. Tell me a bit about yourself? How did you come to work in the health field?
2. What kinds of jobs have you done in the past?
3. How did you get this job?
4. Describe what you do now in your current job?

5. How long have you been working here?
6. How do you feel about your current job?
7. What do you like and dislike about your current job?
8. Are you planning to stay? What are your future career plans?
9. Do you do other jobs as well, or other activities to make money? Tell me about them

10. Tell me about the different kinds of pay which you receive (probe: salary; allowances; user fees; payments from patients; incentives for deliveries; private business etc.).
 - a. Which ones are most valuable for you?
 - b. Why?
 - c. How do they change the way you work?
11. What are the main challenges you face in your professional life?
 - a. How do you cope with them?
12. What sort of changes have you seen over your period of working?
13. Do you know about any policies to encourage health workers to stay in rural areas? Tell me about them
 - a. Have they worked?
 - b. What do you think about them?
14. What do you think is the most important thing for the government to do to get health workers to work and stay in rural areas?

2 The Life History Guide

- A. Introduce the purpose of the study – its aims and scope
 - Assure participant of confidentiality and how it will be maintained
 - Ask for their consent to participate

B. Note details of participant.

6. Interviewee ID		6. Gender		Male <input type="checkbox"/>
7. Date of Interview		7. Age		
8. Name of RHs or HCs		8. No. of children		
9. Province		9. No. of household members		
10. Title interviewee		10. Education		

I would like to understand about your life. Can you draw me a line, starting with your birth and leading to the present day? What are the major events that you would put on it? Describe them to me.

As respondent starts to draw, follow the story with probing questions, such as:

Understanding health worker incentives in post-crisis settings: lessons from health worker in-depth interviews and life histories in Zimbabwe

- 🗨️ When was that?
- 🗨️ Why did you do that?
- 🗨️ What did you enjoy about that?
- 🗨️ How did you manage in that situation?
Where did you go next?

THE OPEN-ENDED Life HISTORIES QUESTIONS CAN BE USED AS A BACK-UP, IF NOT ALREADY COVERED IN THE COURSE OF THE CONVERSATION OVER THE LIFE-LINE:

1. Tell me a bit about yourself? How did you come to work in the health field?
2. What kinds of jobs have you done in the past?
3. How did you get this job?
4. Describe what you do in your current job?
5. How long have you been working here?
6. How do you feel about your current job?
7. What do you like and dislike about it?
8. Are you planning to stay? What are your plans for your future career?
9. Do you do other jobs as well, or other activities to make money? Tell me about them
10. Tell me about the different kinds of pay which you receive (probe: salary; allowances; user fees; payments from patients; incentives for deliveries; private business etc.).
 - a. Which ones are most valuable for you?
 - b. Why?
 - c. How do they change the way you work?
11. What are the main challenges you face in your professional life?
 - a. How do you cope with them?
12. What sort of changes have you seen over your period of working?
13. Do you know about any policies to encourage health workers to stay in rural areas? Tell me about them
 - a. Have they worked?
 - b. What do you think about them?

14. What do you think is the most important thing for the government to do to get health workers to work and stay in rural areas?

C. Informed Consent Form

INFORMED CONSENT FORM

Biomedical Research and Training Institute

Understanding health worker incentives in post crisis settings: Zimbabwe

Lead Investigator: Mr Yotamu Chirwa

Phone numbers: +263 775 429 283

Landline (s): +263 4 735 000/2/4/9

Fax: +263 4 735 033

What you should know about this research:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study.
- The study aims to obtain your perceptions with regard to human resources for health policies from the crisis period to post crisis period in Zimbabwe.
- We cannot promise that this research will benefit you in any direct manner, however information gathered will be used by the Ministry of Health and Child Welfare to formulate its human resources policy in the health sector.
- This research has minimal risk. However, we will take up some of your time during the interviews.
- Your decision to participate or not, in this study, will not affect your participation in any programmes meant to benefit health workers that may result from the recommendations of this study.
- The interviews will be done in a private place where non-participants are not allowed to hear the conversation.
- Please read this consent form carefully. Ask any questions before you make a decision.
- Your choice to participate in this study is voluntary.

Purpose of study: The Biomedical Research and Training Institute (BRTI) is a partner in a global research programme called ReBUILD. As part of this programme, BRTI is conducting a study of *“Understanding health worker incentives in post crisis settings in Zimbabwe”*. You have been identified as someone who could make a valuable contribution to this study. We hope that you will be willing to participate. Please take time to read the following information carefully.

Procedures and Duration: We intend to enrol a total of 310 participants across five HRH cadres from Bulawayo, Masvingo and Bikita for the survey. We also intend to enrol a further 36 HRH cadres for key informant interviews, 38 cadres for In depth interviews who will include managers and from among these select 10 participants for life histories. You will be asked to participate either in a key informant interview, in an individual in-depth interview, a survey or life history where questions about Human resources policies will be asked. The study will be conducted for a period of one year 6 months. Interviewees will be asked for their consent to record the proceedings. The interview will take approximately 30 to 45 minutes at most but may be 1hour for the IDIs and life histories.

Risks and discomforts:There is no anticipated risk in participating in this study. However, we will take up some of your time during the interviews.

Benefits and compensation:You will not directly benefit from participating in this study. This study will mainly benefit the Ministry of Health and Child Welfare through the new knowledge that it will generate which will help in designing human resources policies that will help improve access to equitable health care for the generality of people in Zimbabwe.

Confidentiality: Information obtained from you will be stored confidentially and only authorised research team members will have access to the questionnaires, recordings and notes written during interviews. No addresses or names will be recorded on the forms but only numbers will be used. During the interview non-participants are not allowed to be present, this will ensure a conducive environment for you to feel free to respond to the questions.

Voluntary participation: Your participation in this study is voluntary and you are free to decline. If you decide not to participate in this study, your decision will not affect your future relations with BRTI

and MoHCW and associated organisations. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

Whom to contact: For any questions you may have regarding this study, you are advised to contact the Principal Investigator **ShunguMunyati** on +263 772 128 048 or the Lead researcher **Mr. Y. Chirwa** on +263 775 429 283. If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe on telephone +263 4-791 792 or +263 4-791 193 and fax number +263 4-253979.

Offer to answer questions: Before you agree to participate in this study, ask any questions on any aspect of this study that is unclear to you.

AUTHORISATION

YOU ARE MAKING A DECISION WHETHER TO PARTICIPATE OR NOT IN THIS STUDY. ENSURE THAT THE INTERVIEWER HAS APPENDED HIS/HER SIGNATURE ON THIS FORM TO INDICATE THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL YOUR QUESTIONS ANSWERED AND HAVE DECIDED TO PARTICIPATE.

The date of enrolment in this study that is today's date, MUST fall between the dates indicated on the approval stamp affixed to each page. These dates indicate that this form is valid when you enrol in the study but do not reflect how long you may participate in the study. Each page of this Informed Consent Form is stamped to indicate the form's validity as approved by the MRCZ.

Participant's Consent: My participation in this research study is voluntary. I have read and understood the information above, asked any questions which I had and have agreed to participate. I will be given a copy of this form to keep.

Participant's signature _____ **Date** _____

Name of Interviewer _____

Note: The interviewer must retain one copy of the consent form on file and must give one copy to the Participant.

D. Information Leaflet

Understanding health worker incentives in post crisis settings: Zimbabwe

PARTICIPANT INFORMATION SHEET

The Biomedical Research and Training Institute (BRTI) is a partner in a global research programme called ReBUILD. As part of this programme, BRTI is conducting a study of *“Understanding health worker incentives in post crisis settings in Zimbabwe”*. You have been identified as someone who could make a valuable contribution to this study. We hope that you will be willing to participate if invited. Please take time to read the following information carefully. Talk to others about the study if you wish.

What is the purpose of the study?

The study aims to obtain your perceptions with regard to human resource for health policies from the post crisis period to the present.

What are the possible benefits of the study?

In summary, the results of the study could provide valuable information for the Ministry of Health and Child Welfare about its human resources policy in the Zimbabwe health sector.

Why have I been invited to participate?

You have been invited to participate because you have experience of either implementing human resource policies or the effects of these policies on your career. It is important that we gain the views of a wide range of people from across the health care sector.

Do I have to take part?

It is entirely voluntary. It is up to you to decide. We will be happy to go through this information sheet with you and answer any questions. You are free to withdraw from the study at any time, without giving a reason. If you choose not to participate this will not affect your work or career. You do not have to answer any question with which you do not feel comfortable.

What will I have to do?

Understanding health worker incentives in post-crisis settings: lessons from health worker in-depth interviews and life histories in Zimbabwe

You will be asked to take part in an interview that will last approximately one to one and a half hours. You will be asked about your experiences and perceptions of policies related to health workers' incentives and how these have changed over time.

Confidentiality

All the information you give us during the course of this study will be kept strictly confidential. You will have the right to access the data you provide in order to check its accuracy and correct any errors. Your personal details will not be kept with your responses and so it will not be possible for information you have given during the interview to be linked back to you. The information you give will be stored in an anonymous form. The data will only be analysed by researchers from BRTI and its partner organisations on the ReBUILD project. These include the Liverpool School of Tropical Medicine and Queen Margaret University, both based in the UK. Any data transferred outside BRTI will be anonymised and unidentifiable.

Will I be reimbursed for my time?

We will not pay you anything for participating but your participation will help develop policies that will improve health delivery and working conditions of health workers.

Will you participate in this study? Yes or No

If yes, please complete two copies of the consent form attached. Keep one copy for your records and give one copy to the BRTI staff member who explained the study to you.

For further details, contact **Shungu Munyati** at BRTI (telephone number **+263 4 735 000/2/4**)