



Removing cross-sectoral inequities in incentives to achieve system wide benefits for retention of health workers in Zimbabwe

**Report of a Forum organised by the Biomedical Research and
Training Institute in Zimbabwe**

Held at the Holiday Inn, Harare

14th September 2015

**Funded by a small grant from the Thematic Working Group on
Health Systems in Fragile and Conflict Affected States**

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Introduction

This report is about the Research Communication and Uptake forum, which took place at the Holiday Inn in Harare on the 14th of September 2015. The forum was funded through a grant from the [Thematic Working Group on Health Systems in Fragile and Conflict Affected States](#) (TWG-FCAS). The forum comprised presentations on study findings and a presentation by experts in evidence being translated into policy. The presentation on study findings focused on two ReBUILD areas, health worker incentives and health financing, with the former being the main thrust for research uptake purposes. The grant by the TWG-FCAS to organise an engagement event to share research evidence on post crisis health sector development, and initiatives post the crisis in Zimbabwe provided an opportunity to bring together a multiplicity of actors in the health sector. This report will describe the proceedings with respect to the main forum theme on health worker incentives and give a brief outline of the short presentations on health financing by other ReBUILD researchers, to give participants a general scope of the ReBUILD work that has been done and also to show the linkages between the studies.

The many contributions to the conference are gratefully acknowledged:

- The Ministry of Health and Child Welfare and the Health Services Board who attended the forum and contributed immensely to the debate.
- Funding by the TWG on Fragile and Conflict Affected States.
- The development partners who attended the forum and contributed in clarifying issues.
- The session chairpersons Mrs V T S Chitimbire and DR R Loewenson and the health managers representing the study districts and health providers.

Rationale and description of the forum

The (TWG-FCAS) forum shared research findings, strengthened already existing linkages and initiated new linkages with knowledgeable and experienced key actors responsible for health policy formulation, implementation and monitoring and in particular human resources for

health (HRH) policies across four health service sub sectors, public, rural district council/municipalities, mission and private. National level managers (public sector), Human Resources Managers (Municipality/Rural district councils and private sectors), Association of private hospitals, and health professions associations were invited to be part of the forum. These different individuals are responsible for formulation, implementation of incentive policies and the post crisis effort of stabilising health worker availability in their respective sectors. For other policy makers the forum was a continuation of the engagement dating back to 2011 when the study started.

Objectives

1. To discuss the current policy agenda with policy implementers (government, mission, donors, NGOs) at the operational level of the health system at district and the provincial levels drawn from all providers. (Public, Private, Mission and Rural district councils/Municipalities).
2. To share and discuss early lessons from the study on the incentive environments of health workers in three districts of Zimbabwe
3. To validate and verify the emergent policy agenda as described by the literature and document-based horizon scanning exercise to improve our understanding of the preferred and existing policy agenda on post crisis health systems development.
4. To develop tentative frameworks for policy briefs for specific policy makers across providers that will guide the development of final policy briefs to be shared with consortium partners for refinement and subsequent submission to policy makers in country

Description and status of the Biomedical Research and Training Institute (Hosting Organisation)

The Biomedical Research and Training Institute (BRTI) is a non-profit research institution registered in 1995. BRTI's mission is to promote the health and quality of life of the people of Africa through research and training in the field of public health and biomedicine. BRTI is involved in a research partnership [ReBUILD] with LSTM. The research is funded by the Department for International Development (DFID). The partnership commenced in 2011, and has three components, which are, *understanding changes in health financing policy and poor households' expenditure on health (including user fees)*, *understanding incentive environments for health workers to support access to rational and equitable health services* and *rural posting of human resources for health*. The ReBUILD project is being managed by the Centre for International Health and Policy (CIHP) research unit,¹ within BRTI, responsible for operations and health systems research. Over the years BRTI, in partnership with leading local, regional and international universities and research institutes has conducted studies and published several reports and scientific publications in referred scientific journals. BRTI collaborates with the Ministry of Health and Child Care (MoHCC) in a wide variety of research studies. Additional information on studies and publications can be viewed on (<http://www.brti.co.zw>).

Audiences

The audience at the forum included all the relevant sectors and actors in Zimbabwe's health sector. Specific participants of note who attended were the Ministry of Health and Child Care- Deputy Director HRH, Health Service Board- Director Human Resources, UNICEF, CORDAID, Zimbabwe Evidence Informed Policy Network(ZEIPNeT, Municipality of Bulawayo -MoHCC Department of Medical Social Work, Public Service Medical Investments Private Limited, Community Working Group on Health, FACT Zimbabwe, Rushinga Rural Development Association, Zimbabwe Open University, and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). These organisations are key policy movers in the health sector hence it is important to acknowledge their presence at the forum. There were some participants from NGO's who attended representing programmes in the broad field of

¹ Other units of the BRTI are Research and Diagnostic Laboratories, Public Health, Biomedical and Veterinary Research.

community development². The description and number of participants by sector and gender representation are shown in Table 1 below.

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Sector	Male	Female	Total
Public health	4	3	7
Public- other government departments	2	2	4
Municipality Health	0	1	1
FBO	0	1	1
NGO-Health	1	0	1
NGO-Other	9	2	11
Private health	1	0	1
Private-other	3	2	5
Total	20	11	31

Overview of Forum Proceedings

The forum started off with a welcome by Dr Shungu Munyati, the Principal investigator for ReBUILD, who provided the foundational thinking behind ReBUILD. ReBUILD is concerned with crisis and weakened capacity (Finance /Human capital related) of state actors responsible for the effective functioning of state institutions including the health system. After the welcome the first session, chaired by MRS VT Chitimbire Director of ZACH, ensued. This had three components, a presentation on ReBUILD’s findings, breakaway sessions, and group report back session. This was followed by a session on the translation of evidence to policy, which included a presentation led by Ronald Munatsi from ZEIPNET, an organisation that has experience in engaging policy makers with regards to capacity development in the use of evidence. The session ended with a plenary discussion on the issues that were raised by the presenter.

The forum was an opportune moment that allowed the ReBUILD research team to provide brief findings on other ReBUILD studies which are linked to the study on Health Worker incentives. Further, as part of research communication and uptake activity, there were brief presentations on the impact of changes in user fees charging regimes on the poorest

² See detailed list of participants in Annex 3

households in Zimbabwe, work that is being led by BRTI, and health financing for Universal health coverage in Zimbabwe being led by TARSC.

Health Workers Incentives- Post Crisis - Synopsis of the presentation

This presentation was based on the findings of the ReBUILD component on health worker incentives. The presentation had three components:

- The research presentation
- The breakaway Sessions/Report back
- Plenary Discussion

The Research Presentation

Yotamu Chirwa the lead researcher for the incentives study presented the key findings which have policy implications. The general outline of the presentation covered the study background, research aim and objectives, study methods, findings, followed by the discussion and study conclusions. The presentation gave a background with regards to the key underpinnings of the study evolving around High/Acute vacancy rates for health workers and unattractive working conditions. HRH expenditure reduction and the general deterioration of all facets of the health system due to the crisis were noted. The findings showed that there were key policy responses during the crisis across the sectors which had varying effects on retention. There was better success in the municipality sector than in the national government, Rural District Council (RDC) and mission sector. In the post crisis situation a slight improvement occurred in national government. RDC and mission sector due to new retention initiatives however the municipalities remained way ahead creating a pull factor for HRH in the other sectors

The following conclusions were that in the immediate post crisis period there was reduction in attrition rates in government, mission and RDC sectors. However cross sectoral inequities in remuneration and incentives persist creating an imbalanced internal labour market. The presenter then posed the question concerning what does this say for HRH policies in the post crisis era³.

³ The full power point presentation can be viewed in Annex 2, Presentation 2. More detailed findings can be found on three main reports on www.rebuildconsortium.com

The breakaway sessions/ Report Back

This session was a task oriented activity for participants to assess the utility of the presented evidence. The participants were divided into groups by sector there were three mixed groups and discussed the three set tasks for 20 minutes then report back and discussions.

Group 1 –The task assigned to the group was: Which components of the evidence could be useful to improve specific aspects of HRH.

The group listed the following aspects as being important evidence:

- Responsive retention initiatives in crisis situations.
- Income differentials data between sectors.
- HRH management system contradictions in the sectors.
- Workloads variances and maldistribution of skills in the sectors.
- What motivates health workers to stay in the job
- Contribution of salary and allowances to total income and end of service benefits

Group 2 The Task assigned to the group was: What else can be done to help gain more understanding of the incentive environments in the health sector?

This group pointed out that to gain more understanding of the incentive environments consider the following:

- Redefine the health workers
- Increase the sample size in the next study.
- Identify where the incentives are coming from,
- Who is paying the health workers or incentives?
- Increase the understanding of the budget process.
- Change the methodology (incorporate other cadres not included)
- Undertake Focus Group Discussions,
- Undertake appreciative interviews

Group 3: In view of the general fiscal constraints affecting government what are the opportunities in the evidence for short term interventions to improve incentives for health workers in government and rural areas in particular.

The group noted that the evidence points to a situation of HRH dissatisfaction in RDC, mission and government sectors because of the comparatively poor remuneration with the municipal sector. The opportunities available post crisis characterised by fiscal constraints were.

- Utilising available resources such as the abundant land by allocating it to health workers with robust input support.
- HRH management should be streamlined as the enabling act (Health Service Act 2004) is in place so full implementation is necessary to avoid the inequities in income in the sectors.
- Freezing salary increases in the sectors that are paying more to allow stabilisation of the volatile labour market.
- Support more of the non-financial benefits like accommodation and vehicle purchases

Plenary Discussion

The main issue to emerge from the plenary discussion was the question of why the administration continued to be fragmented yet the Health Service Board has been put in place to harmonise HRH management in the entire health service. There was also the issue of Community Health workers which to some members of the audience are critical health service providers in rural areas more so during the crisis period.

The Zimbabwe Evidence Information Policy Network Presentation

Ronald Munatsi of the Zimbabwe Evidence Information Policy Network presented on translating evidence into policy. This was a short and rapid capacity building exercise for participants on the relationship between evidence, policy making and research uptake. The presentation; was titled Research Uptake (Evidence Translation). He started by defining evidence and policy making while tying the two to research uptake. He pointed out that researchers and policymakers are usually like travellers in parallel universes which contributes to failure in research uptake. With reference to the policy making cycle the presentation showed that the policy making cycle involves a network which includes Cabinet, Parliament, Ministries, Private sector, civil society and donors. These entities interlink in either policy formulation or implementation; agenda setting, decision making; and monitoring and evaluation of the policy processes. Research barriers that usually affect the policy cycle highlighted in the presentation included long timelines of research; lack of relevance of the research; general mistrust and little personal contact between researchers and policymakers; budgetary constraints, political turnover and lack of political will or motivation. Participants were encouraged to use the same rigour that they use in doing research when doing research

uptake .The following evidence translation tools: evidence gap maps, systematic reviews and policy briefs were described to the participants. The presentation pointed out that the research uptake process must be an iterative process where there should be more communication between researchers and stakeholders, and that the coordination should start at the beginning of the research and that there should be a research uptake strategy for every research product or study. There was a question and answer session and a general discussion after the ZEIP Net presentation⁴.

Questions and Discussion

Major issues raised were related to the issue of research ownership and how this often affects evidence uptake. The issue of collaborative research with policy makers to improve research uptake was raised. The people with appropriate skills should be responsible for communicating research results to policy makers and presentations of research results should be tailor made to audience. Stakeholder mapping must be done and it should be continuous. There is need to have research priorities for the whole country not for specific departments.

Project 1: Impact of changes in user fees charging regimes on the poorest households in Zimbabwe.

The presentation was done by Stephen Buzuzi the country lead for Project 1 Health Financing. He stated that the study was conducted in 6 districts selected based on the results from the 2003 Poverty Assessment Survey and several Prices, Incomes, Consumption and Expenditure Surveys (PICES) which were done by ZIMSTAT in 1991, 1995 and 2001. Life histories with 51 patients with chronic conditions and 28 key informant interviews with senior health workers and social service officers drawn from district and national level were conducted. The life histories focused on important health events such as births, deaths in family, episodes of sickness and hospitalisations and how the families were coping with health care costs.

The main research question was: 'How have the budgets of the poorest households been affected by health financing policy as it has evolved before, during and after crisis?'

Key findings were

⁴ The full transcription of the presentation and plenary discussion can be found in Annex 2 presentation 3.

- Declining government budgets to the health sector since the ESAP period as cost recovery measures were being implemented.
- Exemption scheme has underfunded leading to erratic disbursements of funds by the Department of Social Services to the Ministry of Health and Child Care. This has negative repercussions on operations of public health facilities.
- As a result, patients were subjected to re-assessments at point of care and some asked to pay cash or enter into payment arrangements with health facility. Health facilities were forced to collect fees even from AMTO holders as a coping strategy.
- Drug shortages in public health facilities increased the costs for patients who had to buy drugs from private pharmacies. Patients were not obtaining full package of services in public facilities. Public patients were being served by private sector healthcare service providers of specialised services such as scans and drugs.
- User fees present a significant barrier to access because of the frequency with which patients with chronic conditions require services.
- Unexpected consequences for women after husbands lose jobs or die
- Patients cope with cost by avoiding diagnostic procedures, reducing drug doses, ignoring sickness, delaying treatment, borrowing from friends or church, remittances from children, sharing drugs with patients with similar conditions, selling household assets or agricultural produce and by doing piece jobs for money.

The presenter put forward two critical lessons learnt from the study;

- That policy and practice were different; adverse coping strategies were being adopted by service providers out of economic rationality to make it possible for health facilities to continue providing services
- That equity cannot be achieved without adequate government funding of the exemption schemes because there was no guaranteed access to services and adequate resourcing of public health facilities would avert the financial barriers.

The presenter made a call for the following measures to ensure universal health coverage;

- Assessment of population's (patients with chronic conditions) needs and effective allocation of the available health resources based on the needs
- Establishment of a national health insurance scheme with community and stakeholder involvement and policy leadership.
- Improvement of the procurement and distribution of health care products
- Uniform implementation of the exemption policy across public health facilities.⁵

⁵ The full transcription of the presentation and plenary discussion can be found in annex “; Presentation 4.

Universal Health Coverage-Training and Research Support Centre

Presentation was done by Dr Rene Loewenson who is leading the affiliate project on health financing and as background her presentation made the following pertinent points on health financing:

- The need to be clear as a nation on what kind of health services the system trying to deliver for whom, at what cost and how it can be funded.
- The need for a domestically funded health services rather than exogenous funding.
- Outsiders should complement what is being done nationally.
- The need to think of how health services can be funded and also think of long term funding policies on issues like salaries and pensions.
- All the funding commitments cannot be met by international financing since their finances are supposedly just for filling gaps.
- The sustainable solution requires comin up with innovative sources of domestic health financing.

In conclusion Dr Rene Loewenson referred to four key action points:

- For Universal Health coverage to be achieved, there is need for a domestically financed health service.
- There is need to finance the health system so that as the economy grows the health system grows with it.
- When the economy is not growing the health sector should be able to hold fast and be resilient.
- Equitable allocation of resources is key for UHC to be achieved⁶

Concluding Remarks

The forum was a successful endeavor and participants indicated that the evidence presented was very important for the health system. The Principal Investigator pointed out that the forum was the beginning of an intense research uptake and communication process which will see further engagements on the other research area on rural posting. A policy brief on Incentive environments and other REBUILD literature were distributed. The work on universal health

⁶ The full transcription of the presentation can be found in the Annex 2: Presentation 5

coverage by TARSC was distributed in the form of pamphlets and policy briefs.

Forum Evaluation

A short evaluation exercise was conducted to assess usefulness of information disseminated and participant's intention to share the information gathered using a simple questionnaire. The questionnaires were entered into MS excel and transferred to STATA 12 for analysis. Analysis was based mainly on categorization of participants sectors as well as HRH responsibilities if any. Out of the 40 participants who registered, 30 managed to complete the evaluation questionnaires (Males 67% and females made up 33%. The overall rating of the forum was good. Eight six percent (86%) of policy makers and 80% of managers who attended rated the forum as highly useful.⁷

⁷ Detailed evaluation report can be viewed in annex 4: Evaluation analysis