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LIST OF ABBREVIATIONS

AAC	Academic Advisory Committee
APHRC	African Population and Health Research Centre
AU	African Union
CHV	Community Health Volunteer
CHW	Community Health Worker
DHE	District Health Executive
DHMT	District Health Management Team
DMO	District Medical Office
ELB	Epworth Local Board
ESAP	Economic Structural Adjustment Programme
EU	European Union
FGD	Focus Group Discussion
GPA	Global Political Agreement
HRH	Human Resources for Health
HRHT	Human Resource for Health Taskforce
HSB	Health Services Board
HPC	Health Professions Council
HTF	Health Transition Fund
IDRC	International Development Research Centre
MDGs	Millennium Development Goals
MDRTB	Multi-Drug Resistant Tuberculosis
MoHCC	Ministry of Health and Child Care
MHTE	Ministry of Higher and Tertiary Education
MRCZ	Medical Research Council of Zimbabwe
NGO	Non-Government Organization
NHS	National Health Strategy
PHC	Primary Health Care
PHW	Professional Health Workers
PMO	Provincial Medical Office
PMD	Provincial Medical Directorate
PMDME	Provincial Medical Directorate of Mashonaland East
PSC	Public Service Commission
REC	Research Ethics Committee
RDC	Rural District Council
SADC	Southern Africa Development Community
SDA	Sustainable Development Agenda
SDMO	Seke District Medical Office
SHSPH	School of Health Systems and Public Health
SW	Sex workers
TMP	Traditional Midwifery Programme
TNDP	Transitional National Development Plan
VHW	Village Health Worker
WHO-CCS	World Health Organization-Country Cooperation Strategy
ZACH	Zimbabwe Association of Church Hospitals
Zim-Asset	Zimbabwe Agenda for Sustainable Socio-economic Transformation
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

CHAPTER ONE
INTRODUCTION AND POLICY BACKGROUND

1.1 INTRODUCTION

Human resources for health are a critical component, the lifeblood, through which health system building blocks, that include finance, service delivery, governance, information systems and medical products function.[1] The need to overcome the global health workforce crisis is a challenge undermining health system reform of the twenty-first century throughout the world. This challenge was revealed through the World Health Report of 2006 in which an estimated shortage of almost 4, 3 million doctors, midwives, nurses and support workers, particularly in sub-Saharan Africa was identified as a key challenge.[2] This revelation led to the emergence of this challenge on the global health policy institutional agenda that resulted in the establishment of the Global Health Workforce Alliance. This Alliance organized the First Global Forum on Human Resources for Health in 2008 from which the Kampala Declaration and Agenda for Global Action towards human resource for health reform.[3] However, whilst policy interventions have been made towards human resource for health reform throughout the world since, available literature does not provide a detailed narrative on how national human resource for health policy interventions impact local human resource for health systems in peri-urban communities.[4,5] This study sought to detemine how national human resource for health policy interventions impact local human resource for health systems in peri-urban communities using Decision Space Mapping Analysis, towards filling this knowledge gap. Particular focus was on how the Human Resource for Health Policy of 2009 to 2014 impacted the local human resource for health system of Epworth, a peri-urban community in south-east Harare, Zimbabwe.[6] The aim is to contribute towards the health system reform agenda of the twenty-first century through human resource for health reform. The approach in this study is based on the Decision Space Approach developed by Dr. Thomas Bossert of the Harvard School of Public Health (HSPH). Instead of analyzing the decentralization of human resource for health policy as one generalized block, the Decision Space Approach enabled identification of specific policy result areas upon which the Decision Space Approach can then be used to determine decision space, innovation and change.[7]

In the context of this study, a Human Resource for Health Policy Decision Space Mapping

Analysis Conceptual Tool was developed to facilitate inquiry and analysis. The conceptual tool was made up of six result areas around which inquiry and analysis was made. These included: Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Human Resource for Health Information and Research; Labour Relations; and Health and Safety. The Decision Space Approach was then used to determine: the amount of decision space between the principal, Ministry of Health, and the agent, Epworth Local Board, around the six policy result areas; the choices made by the agent with their decision space, range for choice; and the impact towards desired policy outcomes.[1] It is envisaged that this conceptual tool will be used with adaptive modifications in similar studies on human resource for health reform towards health system reform of the twenty-first century and beyond. This study also contributes towards the ongoing Health Policy and Management Research Track of the School of Health Systems and Public Health (SHSPH), in the Faculty of Health Sciences, at the University of Pretoria.

1.2 THE GLOBAL POLICY CONTEXT

1.2.1 The Primary Health Care Approach

It is a health system reform intervention that was officially launched in 1978 when World Health Organization (WHO) member states signed the Alma Ata Declaration.[8,9] However, it was noted that few countries adopted this idea over the years mainly as a result of the failure to understand this approach. Following this realization, WHO in the World Health Report of 2008 proposed that countries make and health development decisions guided by four broad, interlinked policy derections towards reform. These four represent core primary health care principles and include universal coverage reforms, people centred services, health public policies and leadership.[9] On health personnel, the resport prescribed the mobilisation of untapped human resources by communities. It identified health personnel who include Community Health Workers (CHWs), Traditional Medical Practitioners (TMedP), Professional Health Workers (PHW) and Family Members. CHWs were viewed as the first level of contact between individuals and the health care system. However, while this may vary by country or community depending on the needs and resources available for satisfying them, it was suggested that the solution for developing countries is to employ CHWs who can be trained and retrained progressively through modern teaching methods appropriate to the context. The Declaration further suggested that TMedP, with support from the formal health system may become allies in organizing efforts to improve health in the community. Family

members were viewed as playing important roles in preventive care, through discussion on nutrition, childcare, sanitation and family planning. The role advocated for Professional Health Workers was to provide complicated or advanced health care services, which could not be provided by CHWs, TMedP and the Family.[9]

1.2.2 Ouagadougou Declaration of 2008

The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa was intended to reinforce the Primary Health Care Approach in Africa.[10] It focused on nine major priority areas of health which included leadership and governance, service delivery, human resources, financing, information systems, technologies, partnerships for health development, research, and community ownership and participation. With regards to health personnel, it prescribed capacity building for areas including the strengthening the capacity of training institutions, recruitment, training and development, management, staff motivation, retention and HRH information systems. It also prescribed comprehensive HRH policy frameworks developed in the context of national health policies and plans, and partnerships through networks of health workforce stakeholders.[10] However, the World Health Report of 2006 articulated a global health workforce crisis which threatens to undermine health system reform particularly in sub-Saharan Africa.[2] This revelation led to the establishment of the Global Health Workforce Alliance from which the First Global Forum on Human Resources for Health was organized leading to the Kampala Declaration and Agenda for Global Action in 2008.[3]

1.2.3 The Kampala Declaration and Agenda for Global Action

The vision behind this declaration was to overcome incapacities on the human resource for health policy function to the effect that all people everywhere, have access to skilled, motivated and facilitated health personnel in a robust health system.[3] The Agenda for Global Action is built around six fundamental and interconnected strategies including: building coherent national and global leadership for health workforce solutions; ensuring capacity for an informed response based on evidence and joint learning; scaling up health worker education and training; retaining an effective, responsive and equitably distributed health workforce; managing the pressures of the international health workforce market and its impact on migration; and securing additional and more productive investment in the health workforce. These actions will be undertaken according to individual country circumstances,

with regional and global action aimed at supporting an effective country response. In this context, it was recommended that the Global Health Workforce Alliance serves as a catalyst and a global convener to bring together different stakeholders for learning, dialogue, advocacy and joint action. Together with country and regional partners, it was proposed that the Global Health Workforce Alliance accelerates the development of a common framework for essential country baseline information and a benchmarked monitoring of human resources for health in the context of health systems, with the World Health Organization as the lead normative agency.[3] The human resource for health reform agenda was also adopted by the African Union (AU) and the Southern Africa Development Community (SADC).

1.2.4 The African Union and Southern Africa Development Community

In section 4.1.2c of the 2007 to 2015 Africa Health Strategy on Human Resources for Health, it is noted that health sector reforms must promote all aspects of healthcare worker development and retention.[11,12] It was further noted that reform must promote information training, recruitment, deployment and retention, strategic plans, and working and living conditions of health staff. Apart from this, Article 18 of the 1999 SADC Protocol on Health emphasises human resources development.[12] Apart from this, the Human Resource for Health Policy in Zimbabwe was informed by the Millennium Development Goals.

1.2.5 From the Millennium Development Goals towards the Sustainable Development Agenda

The Millennium Development Goals (MDGs) consisted of eight internatonal development goals established following the Millennium Summit of the United Nations in 2000 and contained in the United Nations Millennium Declaration. The MDGs were meant to: eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; and develop a global partnership for development.[13] For Zimbabwe, it was envisaged that the implementation of the Human Resources for Health between 2009 and 2014 would contribute towards the achievement of the MDGs. In 2015, the UN adopted the Sustainable Development Goals (SDGs) with 17 Goals. In particular, Goal 11 of the SDGs which focuses on making cities and human settlements inclusive, safe, resilient and sustainable, and Goal 3 towards ensuring healthy lives and promoting well-being for all at all ages.[14] The global policy context provided

direction to the policy interventions in Zimbabwe. Amongst these include the Plan for Equity in Health of 1981 to 1984 implemented through the first Health for all Action Plan of 1985 to 1990, and second Health for all Action Plan of 1991-1995; the National Health Strategy of 1997 to 2007; and the National Health Strategy of 2008 to 2013.

1.3 POLICT CONTEXT IN ZIMBABWE

1.3.1 Plan for Equity in Health and the First Health for all Action Plan of 1985 to 1990

The Plan for Equity in Health of 1981 presented the new national health policy which took its orientation from the principles of the Primary Health Care Approach.[15,16] It also reflected the broader national objectives of the Transitional National Development Plan (TNDP) of 1980. This plan was made operational through the First Health for all Action Plan of 1985 to 1990. Through this process, the government decentralised the health system to reach out to all levels and sections of society for the purpose of making health services universally accessible to all citizens regardless of their social status or geographical location.[15] The instruments used to implement HRH interventions included National Village Health Worker Programme (VHWP), launched in November 1981. This was complemented by the Traditional Midwives Programme (TMP) designed to upgrade the skills of household level women operatives in identifying at-risk pregnancies, perform basic midwifery, elementary hygiene, and basic child care. Human Resource for Health Policy interventions at this stage sought to reach out to all members of the population through health workers drawn from the community to provide elementary care. This was happening in a context which was characterised by a shortage of professional, skilled and knowledgeable health practitioners to cater for the health needs of the previously marginalised majority of the population.[15] The goal of the policy of equity was also to be achieved through strategies and programmes which included the decentralization of health services management and administration, integration of the fragmented curative and preventive services into a comprehensive health care delivery system, with a special focus on maternal and child health, upgrading of the existing rural health facilities and the construction of new ones, re-orientation of health personnel towards primary health care and the development of additional human resources for health, and promotion of inter-sectoral collaboration and community participation towards equity in health.[16]

It is worth noting that the government gradually integrated church health facilities into the public health sector to create uniform and equitable access to care. It started financing staff

and part of the recurrent costs of the church health facilities through a grant system whilst churches remained owners of the facilities.[16] The Plan for Equity in health policy paper however suggested that private medical sector was not consistent with the primary health care that the government wanted to foster and as such its operations were controlled. Doctors were required to obtain a licence to practice privately in urban areas while private practice by doctors employed on a full time basis by the government or university was gradually phased out. All new medical graduates were bonded to government service for a defined period. While it is generally accepted that the implementation of equity policies in health care was seriously challenged during the 1990s, a few analysts have argued that this process started already during the 1980s. One source attributed this to the spell of economic stagnation in 1983, reported to have led to a reduction in budget allocations to local authorities, an increased pressure to collect fees from patients for services rendered, and a concentration of financial resources and senior manpower at the central level and in the private sector. Other scholars further pointed at the tendencies of bureaucratisation and centralisation, reflecting a *de-facto* lack of support for primary health care by the government. The two views have each been supported by an extensive body of literature, which suggests that they should be seen as complementary rather than contradictory explanations of the same phenomenon, namely that of inadequate support of equity policies during the 1980s.[16]

1.3.2 The Second Health for all Action Plan of 1991 to 1995

It did not differ from its predecessor in that it maintained focus on equity. However it placed more emphasis on quality of care, effective use of resources, value for money and appropriateness of service.[16] Yet at the time of drafting the second action plan, the economic and social climate had changed considerably as the government had adopted the Economic Structural Adjustment Programme (ESAP) in a bid to attain economic stability and growth. This was to be achieved through government austerity measures in the public sector including health. Retrenchments and government budget cuts under the Economic Structural Adjustment Programme were just starting.[16,17] The impact on HRH manifested by way reduced remuneration and non financial incentives owing to reduced public health expenditure by the government. In turn, this resulted in a higher exodus of health workers into the private sector and abroad and in particular fewer doctors and nurses at health institutions, particularly at the clinic and district hospital level who provided for the health needs of the majority. This period was however also characterised by the tendency to begin to

decentralize planning and management responsibilities to the provincial level (PMO), and to a lesser extent to the district level (DMO). However, there was very little corresponding delegation of authority in the area of budgeting and finance, which restricted effective programme implementation at the level of the district and the individual health facility. The Health for all action plan of 1990-95 represented a major policy shift from a National Health Service Model, in which the government itself organises and delivers health services, towards a Mixed Public Insurance Model in which health services would to a large extent continue to be publicly financed but institutions outside the Government would deliver them.[16,17] The National Health Strategy 1997-2007 was implemented to revitalise the post ESAP health sector under the theme Working for Quality and Equity in Health.

1.3.3 National Health Strategy of 1997 to 2007

It reaffirmed several of the core principles and values that had guided health policy making in earlier years.[16] The document envisaged the testing of innovative new approaches to manage the delivery of services so as to: enhance access, community satisfaction and local accountability; aim at quality; give priority to disease prevention, health promotion and protection; widen stakeholder participation; develop a consensus building strategy; and establish a wider awareness regarding the impact of social and economic policies on health. The prescribed instrument included the creation of coordinated and welfare-oriented public private partnerships in health. The document set a number of ambitious targets for the year 2007 which were then incorporated into a Three Year Rolling Plan 2000-2002.[16] It is however worth noting that the health sector continued to experience serious challenges particularly regarding the brain-drain of health workers which severely crippled the functioning of the health system. In this context, a Presidential Commission of Review into the Health Sector was established to inquire into and advise the government and parliament on ways of arresting the decline in the quality of health services.[18] The report from this commission, of which an abridged version was released in April 1999 suggested a grim picture of the health sector and put much emphasis on the need to strengthen human resources within the sector. This resulted in the creation of the Health Services Board (HSB) in 2005 to become the human resources arm of the health sector in Zimbabwe, and a mechanism through which health personnel policy interventions could be pursued. It was created through an Act of Parliament, Health Service Act (Chapter 15:16 No. 28/2004) and this Act legalised the establishment of the Health Service Board which became operational on

the first of June 2005.[18,19] However, whilst the effective functioning of this board affected by the lack of a human resource for health policy, more seriously, it was severely undermined by the unfavourable socio-economic environment experienced in Zimbabwe particularly during 2007 and 2008. The socio-economic challenges and the political impasse that followed led to the signing of the Global Political Agreement (GPA) of 2008. This provided the foundation and context towards which the Human Resource for Health Policy was implemented between 2009 and 2014.[20]

1.3.4 The National Health Strategy 2009-2014

The 2008 Global Political Agreement paved way for the adoption of the National Health Strategy 2009-2014.[20] It laid the foundation upon which the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) was re-defined within the context of the World Health Organization Country Cooperation Strategy (WHO-CCS).[20,21] To this end, the most notable intervention was the Health Transition Fund (HTF), a multi-donor pooled fund set up to support the Ministry of Health and Child Care in implementing health policy. It was a project funded by development partners to strengthen the health system in reducing maternal and child mortality in line with the Zimbabwe government's priorities. Canada, Ireland, Norway, Sweden, the United Kingdom (UK) and the European Union (EU) contributed to the fund with the United Nations Children's Fund (UNICEF) as the implementing partner. It was launched in 2011, under the guidance of ZUNDAF coupled with the support from other donor funding.[22] However the GPA ceased to exist following the 31st July 2013 General Elections which were conducted in line with the New Constitution that had been adopted in May 2013 following a Referendum in March of the same year. The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset), an economic blueprint adopted in 2013, was adopted to also provide guidance to the implementation of healthcare worker policy. It was adopted to enable gradual transfer of technical and financial responsibility for implementation socio economic policy to the government. For Human Resource for Health, policy implementation was guided by the Key Area on: Access to basic Health Services; of the Cluster on Social Services and Poverty Reduction.[23] Apart from this, the National Health Strategy 2009-2014 set forth a Human Resource for Health Policy and Strategy, the result of which was the 2009 Human Resource for Health Policy, implemented through the Human Resource for Health Strategic Plan of 2010 and 2014.[24,25] The vision behind this policy is to ensure that Zimbabwe has adequate

numbers of well qualified, well managed, remunerated and highly motivated health workers who provide equitable, accessible, affordable and sustainable high quality health services to all population groups. The policy goal is to plan, produce, develop, deploy, manage, finance and retain Human Resource for Health in adequate numbers for effective and efficient management of health service delivery. It consisted of four main result areas which included: Human Resource for Health Planning and Financing; Production, Training and Development; Deployment, Utilization and Management; and Human Resource Information and Research.[24,25]

Human Resource for Health Planning and Financing focused on demand and supply forecasting, and financial budgeting for health personnel. In addition, the aim was also to facilitate strategic partnerships with the donor community to facilitate the human resource for health policy implementation. Production, Training and Development focused on the production, and basic and post-basic training and development of health cadres. The objective of behind this aspect was to strengthen capacity for training of critical human resources for health and to increase the production output of health workers with critical post-basic and postgraduate qualifications. Emphasis was also on the training of managers in leadership and management skills on a continual basis.

Deployment, Utilization and Management covered matters related to the deployment, retention and management of performance for all categories of health personnel. The objectives in this were to ensure availability of qualified staff, ensure equitable distribution of qualified staff, and manage staff motivation, performance and employee relations. The sub-policies in this intervention included deployment, retention, and utilization and management. Deployment was guided by the need to ensure an equitable distribution of personnel to maintain a fair balance between rural and urban areas, at various levels of institutions, and taking into account the skills mix appropriate to those types of institutions. It was also meant to be sensitive to the worker's personal circumstances and conditions, and taking cognizance of the information concerning output of training institutions, staff in post and anticipated staff loses so as to provide guidance to deployment. Retention was aimed at reducing brain drain so as to retain the staff that the country produces. To achieve this, the intended policy measures included the reviewing of remuneration packages and conditions of service so that they may be comparable to those of the private sector and the region. It also involved

engaging development partners for co-operation programmes that sustain human resources retention and a scientific grading system that takes account of roles, skills and responsibilities of health cadres. The aim was also to improve the work environment by providing the tools of trade and welfare facilities for the staff. Utilization and management was intended to promote health employer-employee relationships for a well-defined system of rights, obligations and sanctions enforceable at law in order to promote worker morale, and production within the spirit of mutual respect. To this end, the aim was to make sure that healthcare workers were conversant, and complied with the laws, policies, regulations and rules governing their employment conduct including compliance with professional ethics, oaths, pledges and other obligations. Apart from this, the aim was ensure that the workforce was not deprived of its rights and privileges.

Human Resource Information and Research focused on the development of a comprehensive Human Resource for Health information system and the conduct of research to support the implementation of all policy objectives set. Comprehensive information enables management to use the resulting data for future planning and budgeting. Research plays a critical role in Human Resources Health as both basic and processed data can be collected and used effectively. Such information can be used for assessing progress, recommend strategies for addressing problems. Issues such as workload, staffing mix, causes of attrition and migration can also be looked at through the use of the research. The objective of this intervention was the development of a Human Resource for Health Information System that also includes the development of a National Observatory. This will enhance the timely production of data and information, research-based reports that will in turn aid in evidence based policy formulation, planning and management of the Human Resource for Health. In turn, this will facilitate better decision making thereby enhancing the effectiveness of implementing the Human Resources for Health Policy. The development of the National Observatory entails having all health facilities throughout Zimbabwe creating an interactive computer network through which a central healthcare worker database is maintained. This database will contain up to date details of the number and status of healthcare workers at each facility for the purpose of keeping the Ministry of Health and the Health Services Board up to date with worker information to facilitate planning and budgeting.[24,25]

1.4 THE ORGANIZATION OF HEALTH SERVICE DELIVERY IN ZIMBABWE

Health services in Zimbabwe are delivered at four levels, each of which has a different function in the system of patient referral. Rural health centres, rural hospitals and town (municipal) clinics serve as the first entry level (primary level of care).[16] District hospitals constitute the first referral level (secondary level of care) while provincial and general hospitals are meant to serve as the second referral level (tertiary level of care). Central and Specialised hospitals are responsible for the third referral level (quaternary level of care). These Central hospitals are only found in Zimbabwe's two largest cities, Harare and Bulawayo, which have two central hospitals each. A District hospital provides in-patient as well as outpatient care and has emergency surgical and obstetric care. Staff at this facility comprises one or more medical doctors and several nurses midwives, plus a laboratory technician or aide, a pharmacy assistant and a radiology technician. Rural health centres, rural clinics, urban council (urban, municipal, town or local board) clinics provide limited curative care, including delivery care and referral of high-risk deliveries. They further provide preventive services (antenatal care, post-natal care, family planning, child growth monitoring and vaccination), promotional services (health education and environmental health services) and disease surveillance. The staff at these facilities usually consists of one or more nurses of which at least one has midwifery qualifications one or more nurse aides, and an environmental health technician. They usually do not have any medical doctors and they may keep in-patients, mainly for observation.[16]

It is worth noting that health services in Zimbabwe are delivered through sectors that include the public, private not for profit, and private for profit. The public sector includes two main actors namely; health facilities operated by the Ministry of Health and Child Care; and facilities operated by local authorities, under the Ministry of Local Government.[16] The private not for profit sector consists of facilities operated by voluntary organizations who include Non Government Organizations (NGOs) and missions. Non Government Organizations mainly implement health programmes to complement government effort in certain areas. Missions are church owned facilities that fall under the Zimbabwe Association of Church Hospitals (ZACH). They receive grants from government to facilitate the provision of health care to people in their catchment areas. The private for profit sector consists of facilities which provide healthcare services on a market-basis and are owned by private individuals and organizations.[14,16] The local human resource for health system in Epworth peri-urban

community consisted two local municipal clinics, one mission clinic, and seven private surgeries. Inquiry was made on all these health facilities.

1.4.1 Regulations on health care provision in Zimbabwe

The role of healthcare workers in health service provision in communities is derived from Section 29 of the Constitution of Zimbabwe, particularly Sub Section 1 which states that the state must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.[26] In addition, the Public Health Act (Chapter 15:09) makes provisions for the establishment of the Health Ministry, District Health Management Committees, Local Health Authorities, Health Committees and duties thereof.[27] Apart from this is the Medical Services Act (Chapter 15:13) which governs the establishment of health facilities at all levels of society, and the Health Services Act (Chapter 15:16), which governs the establishment of the Health Services Board, and the Health Professions Act (Chapter 27:19) which provides for the establishment of the Health Professions Authority of Zimbabwe and councils for practitioners. The Labour Act (Chapter 28:01) governs relations between employers and employees.[28-31] The Human Resource for Health Policy and provision of health services in Zimbabwe is implemented within these legal frameworks.

1.4.2 Local Boards and the legal frameworks in Zimbabwe

Local boards occupy the lowest position in the hierarchy of urban councils because they are established in settlements that have very small populations but have a potential to grow into big urban centres. Local Boards are also established where a centre has peculiar circumstances and where they would require Government assistance for sustain themselves. In Zimbabwe, there are four such Local Boards established at Hwange, Ruwa, Epworth and Chirundu.[32] Their existence is governed by PART II of the Urban Councils Act (Chapter 29: 15) of Zimbabwe that also provides for the establishment of municipalities, town councils, and local government areas. Section 6 under PART II of the Urban Councils Act (Chapter 29: 15) makes provisions relating to the establishment, alteration or abolition of local government areas and local boards.[33] This provision is specifically made under Paragraph (a) of Subsection (2) which states that the President may, subject to this Act, by proclamation in the Gazette, after any local authority concerned has been consulted establish a local board for that area and shall assign a name to that board. Subsection 4 provides that where a local board is being established for a local government area, the Minister shall issue a warrant in which

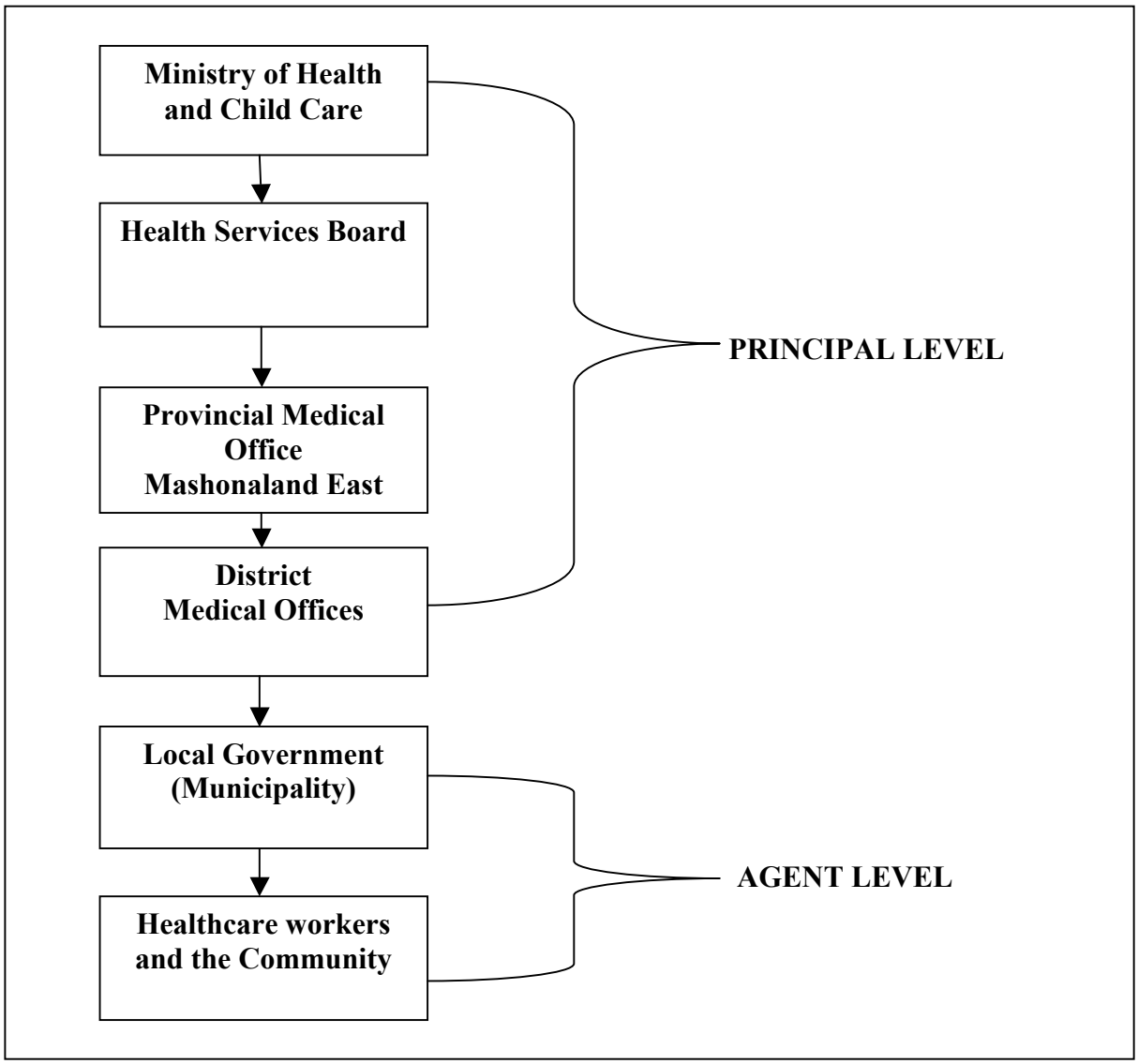
he specifies the number of members, including their appointment and/or election, who shall constitute the local board. Section 7 under PART II makes provisions relating to vesting of administration of local government area in council or person. Sub section (1) of this section provides that the Minister may, after consultation with a council, by statutory instrument, vest in that council the administration, control and management of a local government area and any services provided by the State in that area, and any regulations in force in that area. Paragraph (a) of Sub section (2) makes provisions that the Minister may give directions or impose conditions relating to the administration, control and management of the local government area concerned, including the provision of services therein. Sub section (3) provides that the Minister may, after consultation with the person and any local authority concerned, by statutory instrument, vest the administration, control and management of a local government area and any services provided by the State in that area in any person, and any regulations or by-laws in force in that area.[33] In order to understand the context of this study, an understanding of the organization of public health services in Zimbabwe is desirable.

CHAPTER TWO
LEVELS OF DECISION SPACE AND STUDY QUESTIONS

2.1 DECISION SPACE LEVELS IN ZIMBABWE'S HEALTH SYSTEM

Governance of Human Resources for Health in Zimbabwe places at four levels outlined in Fig 1 namely: the central, provincial, district, and urban council (municipal).[16] However, there are two main levels of decision space namely the Principal and Agent in this system.

Fig 1: The Organizational Structure and Decision Making Levels



Source: Bijlmakers[16,20]

Decision space at the principal level vests in the Ministry of Health, and Health Services Board, and its deconcentrated field offices at provincial and district levels.[16,20] At an agent level, local governments, which are also devolved creations of the centre also enjoy decision space.[32] It is through these levels that national human resource for health policy was implemented between 2009 and 2014.

2.1.1 DECISION SPACE AT THE PRINCIPAL LEVEL

2.1.1.1 The National Human Resource for Health Taskforce

Whilst executive authority on healthcare worker policy vests in the Minister of Health, there are also other actors at this level who facilitate such decision making. These actors make up a National Human Resource for Health Taskforce consisting the Health Services Board, Provincial Medical Officers for each of the country's ten provinces, representatives from other Ministries (such as the Ministry of Finance), Zimbabwe Association of Church Hospitals (ZACH) and other organizations from the donor community. This taskforce was set up in 2009. The decision role of actors at this level is to formulate, support, regulate, supervise, monitor and evaluate the implementation of Human Resource for Health Policy.[20,24] One of the key roles of the Ministry of Health at this level is to collaborate with the Ministry of Finance and Economic Development (MFED) for financial support. Apart from this, the Health Services Board through the Ministry of Health and Child Care also collaborates with the Ministry of Higher and Tertiary Education (MHTE) towards the production of medical practitioners, and the Zimbabwe Association of Church Hospitals, the Health Professions Authority (HPA) and Health Professions Councils (HPC) for complementary support. In addition, there is collaboration with the the Ministry of Public Works, which provides infrastructure in health institutions, the Ministry of National Housing and Social Amenities, responsible for the construction of government buildings including health staff quarters, and the Ministry of Foreign Affairs responsible for health international relations. There is also collaboration with the donor community in the context of the Zimbabwe United Nations Development Assistance Framework[20,24].

2.1.1.2 Provincial and District Medical Offices

Executive authority in each province is vested in the Provincial Medical Officer. However, decision making is undertaken through the Provincial Health Executive consisting District Medical Officers, representatives of government ministries in the province, and provincial

arms of the Zimbabwe Association of Church Hospitals (ZACH), and donor organizations. At this level, the decision role of actors is to translate national human resource for health policy priorities into provincial objectives through planning, budget allocation to government health facilities, and monitoring and evaluation. The Provincial Medical Office mirrors the Ministry of Health in the province. It is a deconcentrated arm of the ministry which facilitates policy implementation through the District Medical Office (DMO).[20,24]

The District Medical Office represents the Provincial Medical Office at a district level. Decision making is undertaken through the District Health Executive. This District Health Executive (DHE) is headed by a District Medical Officer, who mirrors the Provincial Medical Office at this level. Apart from this, the executive consists of a District Nursing Officer, District Pharmacist, District Health Service Administrator and a District Environmental Health Officer. In addition, there is a District Health Management Team (DHMT) comprising of the five DHE members plus the chairperson of the Health Committee of the Rural District Council (RDC), District Council Executive Officer for Health, the District Administration, Community Health Officer and representatives of all health institutions (Sisters in Charges/Health personnel managers), including the missions in the district. The task of the DHMT is to supervise all health facilities (agents) in the district regardless of whether they are municipal/council, mission andf private clinics.[20,24]

2.1.2 DECISION SPACE AT THE AGENT LEVEL

2.1.2.1 Urban Councils

Urban councils are devolved agents through which decision space towards the functuining of the local human resource for health system takes place. Zimbabwe has different types of urban councils namely City Councils, Municipal Councils, Town Councils and Local Boards. City Councils have the highest status in Zimbabwe, and are established in Harare, Bulawayo, Gweru, Mutare, Kwekwe and Kadoma. Apart from these are municipal councils which occupy the position below city councils in the hierarchy of local authorities. These include, Bindura, Chegutu, Chinhoyi, Chitungwiza, Gwanda, Kariba, Marondera, Masvingo, Redcliff and Victoria Falls. Urban Councils also consist of town councils. These are centres that have grown from service centres in the rural areas to a size sufficient for them to stand-alone. There are eight in number namely Karoi, Norton, Shurugwi, Zvishavane, Rusape, Chipinge, Plumtree and Chiredzi. The lowest on the hierarchy of urban councils are local boards

established in settlements that have very small populations but have a potential to grow into big urban centres. Local Boards are also established where a centre has peculiar circumstances and where they would require Government assistance to sustain themselves. There are four such local boards established at Hwange, Ruwa, Epworth and Chirundu.[32] The study area of this research was Epworth, a peri-urban community in south-east Harare, Zimbabwe.

2.2 THE STUDY OBJECTIVE

In this context, the objective of this study was to develop a Human Resource for Health Decision Space Mapping Analysis Conceptual Tool.[1] Using the Decision Space Approach, this tool was then used to determine how the decentralization of Zimbabwe's Human Resource for Health Policy of 2009 to 2014 impacted the local human resource for health system in Epworth peri-urban community.

2.2.1 Research questions and study aims

In this study, the Decision Space Approach was used to answer the central research questions that included:

- What is the range of actual exercised decision making authority (decision space) over six human resource for health policy functions that included: human resources planning and financing; production, training and development; deployment, retention, utilization and management; human resource for health information and research; labour relations; and health and safety in Epworth peri-urban community between 2009 and 2014?
- What choices (innovations) were made by the agent (Epworth Local Board) with their decision space (range of decision making authority) over the six human resource for health policy functions?
- What were the policy outputs and outcomes (impact) of the choices made on the local human resource for health system in Epworth between 2009 and 2014 towards the health system reform agenda?

To achieve above mentioned objective and provide answers to the questions above, the study had three specific aims. These included:

- Define the range of choice the local board of Epworth was able to exercise over the six human resource for health policy functions;
- Determine what they did or failed to do with range of choice; and
- Explore policy outputs and outcomes from choices towards human resource for health reform in Epworth between 2009 and 2014.

The objective, research questions and study aims were complemented by the goals of Zimbabwe's Human Resource for Health Policy of 2009 to 2014 which were outlined in the Human Resource for Health Strategic Plan of 2010 to 2014.[24,25]

CHAPTER THREE
LITERATURE REVIEW AND THE FRAMEWORK OF ANALYSIS

3.1 LITERATURE REVIEW

Literature on health system reform does not provide much evidence on how national human resource for health policy interventions impact local human resource for health systems in peri-urban communities. To start with, it appears that human resource for health reform in itself has been overlooked in literature on health system reform as more focus has been on other aspects of health system appraisal.[34,35] For instance, whilst the Decision Space Approach has been used towards health system reform, available literature suggests that more focus was on aspect of the health system that include service organization, governance rules, financing, access rules. On human resources for health however, focus was only on three result areas namely salaries, contracts and civil service.[36,37,38]

3.1.1 Human Resource for Health Reform in Health Systems

It appears that studies on health sector reform have more often focused more on aspects of health system reform that include changes in financing or organisational structure, but neglecting a key resource, human resources for health.[34] Consequently, this has resulted in an inappropriate fit between the functioning of human resources for health and the health system reform process through, for instance, inappropriately skilled staff for new tasks, poorly motivated staff, or even serious opposition to the reforms. In addition, it has also been is also noted that the health system reform itself presents a necessity for human resource for health reform. This is necessitated by the new structures, processes and systems, of the health sector appraisal, which modify the ways in which health workers interact with their workplace.[35] Consequently, the impact of health sector reform necessitates the modification of critical aspects of the health workforce functions in result areas which include labour conditions, degree of decentralization of management, required skills and the entire system of wages and incentives. This is because human resources in health are crucial agents through which changes may be effected in any health system reform effort.[35,40]

In addition, other studies on health care reforms propose the need for fundamental changes to the ways in which the health workforce is planned, managed and developed within the transformation process of national health systems. Whilst issues involved in such transition

remain complex, their importance and the need to address them in a proactive manner are considered vital for reforms to achieve key policy objectives. The importance of this position was articulated in studies on health sector reform in Latin America.[41,42] Whilst it is acknowledged that human resources are the most important assets of any health system, and health workforce problems have for decades limited the efficiency and quality of Latin America health systems. World Bank-led reforms aimed at increasing equity, efficiency, quality of care and user satisfaction did not attempt to resolve the human resources problems that had been identified in multiple health sector assessments. In this context, the two most important reform policies, decentralization and privatization, had a negative impact on the conditions of employment and prompted opposition from organized professionals and unions. As a result, the human resource constraints affected the success of health health sector reforms in this region.[43]

This position is supported by the view in other literature in which it is noted that the increased attention paid to the development of health policies is undermined by the failure to make room for issues of human resources which makes it difficult to address healthcare worker challenges thrown up by health system reforms.[44] To some authors, these challenges imply the importance of human resources management (HRM), toward improving overall patient health outcomes and delivery of health care services. In this context, challenges in the health care systems in Canada, the United States of America and various developing countries were examined, with suggestions for ways to overcome these problems through the proper implementation of human resources management practices. It was recommended that proper management of human resources is critical in providing a high quality of health care.[45,46] In addition, literature also recommended the need to improve in the depth, scope and quality of research and studies on human resource for health reform in the context of health sector appraisals by incorporating functional, institutional and policy dimensions.[46] It appears that this has contributed towards the global health workforce crisis, a challenge articulated in the World Health Report of 2006 as a major constrain affecting health system reform of the twenty-first century throughout the world.[2] In addition to this, the Decision Space Approach has also been used towards health system reform. However, it also appears that more focus in studies on countries that include Bolivia, Zambia, Ghana, Uganda, and Philippines has been on other aspects of health systems that include governance rules, access rules, finance, and service organization.[36,37,38] In addition, in another study on Pakistan using this approach, it

was also established that ther was no detailed narrative on human resources for health as more decision space mapping analysis focused on other aspects of the health system that included financial management, strategic and operational planning, and service organization.[39]

3.1.2 Human Resource for Health Decision Space Analysis

As outlined in Table 1, the determination of salaries[i] in Bolivia, Zambia, Ghana, Uganda and Philippines is characterised by narrow decision space. Decision making on salaries for health personnel is determined by the central health agencies in these countries.[36,37,38] However, in Colombia, local health authorities enjoy moderate decision space in that they are allowed to determine salaries within defined central government parameters. This is different from Chile where the New Statute of Primary Care Workers of 1989 resulted in all decision making on salaries being made by local health authorities who enjoy wide decision space. As a result of this, health workers in local authorities enjoy favourable salaries, which have contributed towards their satisfaction and commitment to the health service.

On contracts,[ii] the majority of the case study countries that include Chile, Colombia, Zambia and Uganda local municipalities enjoy wide decision space. It means that they are allowed total decision making authority to hire non-permanent health personnel as outlined in Table 1 above. It is only in Ghana where the central health authority makes decisions on behalf of the local health authorities that enjoy Narrow Decision Space on this matter. In Bolivia and Philippines, the local health authorities are allowed moderate decision space that allows them to hire non-permanent health personnel within the parameters of the central health agency.

Studies have also been carried out to analyse decision space on the hiring of permanent health personnel by local health authorities. Studies on Bolivia, Colombia and Ghana suggest that there is narrow decision space on the hiring of permanent health personnel.[iii] It implies that the central health authorities exercise centralised decision-making authority on health personnel in the local authorities. In Zambia, Philippines and Uganda, local health authorities

[i] Salaries refer to decision making power towards the determination of salary levels for health personnel in local health systems (local municipal health personnel and healthcare workers at local private clinics).[1]

[ii] Contracts refers to the hiring of health personnel in local health systems on a temporary basis.[1]

[iii] Civil service is the employment of permanent health personnel to work in local municipal clinics by the central government through the Ministry of Health, on the civil service payroll.[1]

are allowed moderate decision space in that they are allowed to make decisions on the hiring of permanent health personnel within the defined parameters of the central health authorities. It is only in Chile where the local health authorities enjoy wide decision space. It appears the New Statute of Primary Care Workers of 1989 has resulted in the empowerment of local health authorities in this countries in as far as decision making on permanent healthcare workers is concerned.

Table 1: Summative comparison of HRH decision space in different countries

	Range of choice		
	Narrow (Defined as centralised decision making power in which the central government retains all decision space over the local level)	**Moderate** (Defined as conditioned decision making for the local level by the centre, influenced by incentives, defined parameters and sanctions)	**Wide** (Defined as decentralised decision space in which the local level is allowed unconditioned decision making)
Functions			
Human Resources			
Salaries	Bolivia/ Ghana /Zambia/ Philippines/Uganda	Colombia	Chile
Contracts	Ghana	Bolivia/ Philippines	Chile/ Colombia/ Zambia/ Uganda
Civil service	Bolivia/ Colombia/ Ghana	Zambia/ Philippines/ Uganda	Chile

Adapted from Bossert[36,37,38]

In addition to the above, there was also another study on Human Resource Decision Space Analysis in Pakistan's decentralization-oriented reforms of August 2001. In this, focus was on health system aspects that include performance management, hiring, transfer, substitution, disciplinary actions, promotion, contracting and firing of healthcare workers. It was established that human resource management is standardized across provinces. However, at lower levels, authority in hiring, transfer, substitution, disciplinary actions, promotion, contracting and firing for each category of district officials varies from province to province. Control over medical staff (doctors and nurses) is exercised both by provincial and district

governments. It was concluded that whilst decentralization districts that had higher levels of decision space, capacity and accountability were least likely to perform well on some dimensions of human resources staffing as a result of the failure to make effective choices.[36,37,38] Despite these contributions, it appears that there is need for a more detiled narrative on human resource for health reform policy interventions, towards addressing the global health workforce crisis undermining health system reform as revealed in the World Health Report of 2006.[2]

3.1.3 Towards the Human Resources for Health Reform Agenda

This revelation led to the emergence of this challenge on the global health policy institutional agenda that resulted in the establishment of the Global Health Workforce Alliance. This Alliance organized the First Global Forum on Human Resources for Health in 2008 from which the Kampala Declaration and Agenda for Global Action towards human resource for health reform.[3] The vision behind this declaration is to overcome the global health workforce crisis through building capacity around the Human Resource for Health Policy Functions to the effect that health systems and people everywhere, have access to skilled, motivated and facilitated health personnel in a robust health system. The Agenda for Global Action is built around six fundamental and interconnected strategies. These six strategies include: building coherent national and global leadership for health workforce solutions; Ensuring capacity for an informed response based on evidence and joint learning; Scaling up health worker education and training; Retaining an effective, responsive and equitably distributed health workforce; Managing the pressures of the international health workforce market and its impact on migration; and Securing additional and more productive investment in the health workforce. These actions will be undertaken according to individual country circumstances, with regional and global action aimed at supporting an effective country response.[3] The human resource for health policy functions around which capacity must be built are articulated in literature on this area.

Contemporary human resource for health reform recognizes healthcare personnel as the backbone of any health system without which it would not exist. In this regard, it is articulated that capacity must be built around human resource for health policy functions. These functions include: Human Resource Planning; Recruitment and Selection; Appointment and making a start; Motivation and Leadership; Staff development and

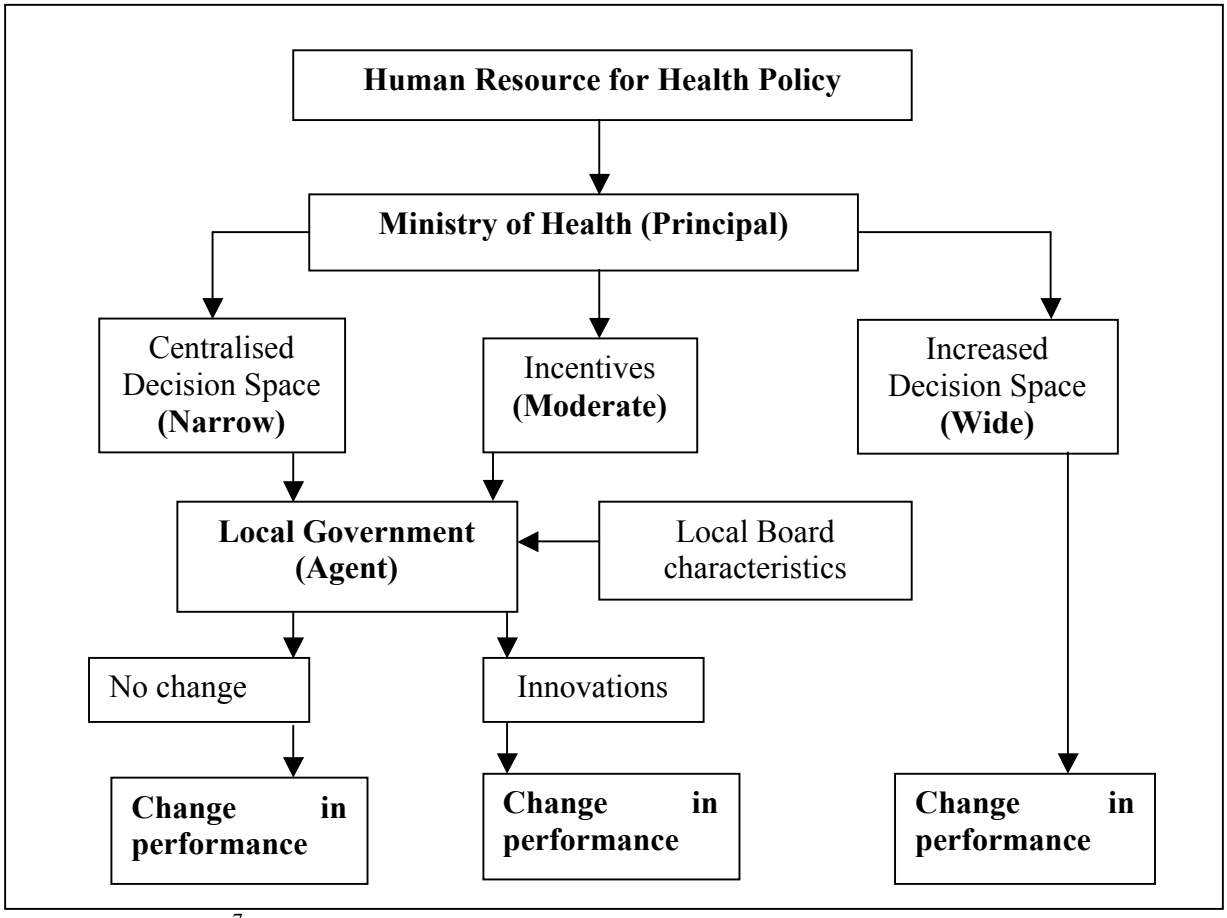
Training; Performance review; and Handling disciplinary conflicts and work disputes.[40,41] In addition, other literature also suggests health worker management activities which include: Allocation of work and supervision; Promotion and career development; Compensation; Labor relations; and Employee security and health welfare.[42] Implied in this is the need for reform around the human resource for health management functions beyond the aforementioned salaries, contract and civil service. These functions include: Human Resource Planning; Recruitment and placement; Training and development; Allocation of work and supervision; Motivation and Leadership; Performance review; Labor relations; and Employee security.[40,41,42] Without understating the role played by other aspect of health systems in the reform process, there is no doubt that these are obsolete without human resources to make them functional. Therefore, there is a need for a more detailed narrative on how national human resource for health policy interventions impact local human resource for health systems in peri-urban communities towards health system reform.

3.2 DEFINING KEYS TERMS IN THIS STUDY

3.2.1 The Decision Space Approach

Decision space is a range of effective choice (decision space/decision making power or authority) that is allowed by the central authorities (the principal) to be utilized by local authorities (the agents).[7] In the context of the Decision Space Approach outlined in Fig 2, the range of choice can either be wide, moderate or narrow. Wide decision space is decentralised decision making authority in which the local level is allowed total indepencence to innovate. Moderate decision space is conditional decision making authority inwhich the local level is influenced by incentives, defined rules and regulations, and parameters and sanctions. Actors may only also engage in functional innovation in which they make modifications and adjustments to suit local contexts. Narrow decision space is centralised decision making authority in which the principal (central government) retains all decision space over the local level. All decision space is localised to the effct that it can result in change or a lack of it, depending on the characteristics of the Agent (Local Government).

Fig 2: The Decision Space Approach



Source: Bossert.[7]

The characteristics of the Agent, are the factors which influence their ability to make effective choices. They include levels of technical, human resource, financial and material resource capacity. In addition, they also include local contexts, systems and structures.[1] The change in performance is the effect that the choices have on the performance. In other words, it the impact of decision space towards desired outcomes.[7]

3.2.2 Indicators of decision space

The indicators of decision space include laws and regulations (and national court decisions), political rules of the game, administrative norms and standards, and the financial and technical capacity to enforce decisions. The actual ("formal" or "informal") decision space may also be defined by lack of enforcement of these formal definitions that allows lower level officials to "bend the rules." These indicators of space have recently been used in previous studies towards health system reform throughout the world. For instance, in Bolivia, Chile, Colombia, Philippines, Uganda and Zambia, they were used to determine decision

space in health system functions that include Finance, Service organization, Human resources, Access rules and Governance rules. [36,37,38] In addition, these indicators were also used in studies on Pakistan to determine decision space for various functions of the Health Department that included human resources management, financial management, strategic and operational planning, and service organization.[39] Apart from determining decision space between the principal and the agent, the Decision Space Framework prescribes the understanding of the choices local officials (agent) make with their range of choice, local characteristics (capacity) and effect these choices have on the performance of health systems (policy outputs and outcomes).[7]

3.2.3 Key issues in studying health system reform using decision space

There are a number of isses that need to be defined clearly in studying the decentralization of human resource for health policy.[39] Firstly, decentralization is complex and therefore it is important to define the decision-making authority (decision space) granted to municipalities. Secondly, decentralization involves granting decision space with different ranges for different human resource for health policy functions that may include human resource planning and budgeting, and/or training and development. In this context, local officials may have a wider range of choice over some policy functions compared to others. This makes it important to analyze choice over these different functions in detail. Thirdly, what is formally allowed in law may not be the range of choice that is actually practiced by local officials which makes it important to determine choices that local officials actually make. Fourthly, it is necessary to determine the capacities (financial, technical, and human resource) that local officials have to have effective choices over different policy functions. Fifthly, the role of local accountability may vary considerably and its influence on decision-making may be positive or negative. And finally, the differences in decision space, capacities and accountability may have an impact on the effective performance of the municipalities in the key policy functions that have been decentralized.[39]

3.3 FRAMEWORK OF ANALYSIS

3.3.1 PRINCIPAL AGENT APPROACH

The Principal Agent Approach was used as it best fit the context and objectives of the study. Other theories and approaches that have been used on this area include the Public Administration Approach, Social Capital Approach, and Local Fiscal Choice Approach.[7] The

Public Administration Approach focuses only on the distribution of authority and responsibility for health services within a national political and administrative structure through a four-fold typology of different forms of decentralization namely deconcentration, delegation, devolution and privatization. However, the weaknesses of the approach are that it does not provide much guidance for analyzing the functions and tasks that are transferred from one institutional entity to another and does not identify the range of choice that is available to decision-makers at each level. The Local Fiscal Choice Approach was developed by economists to analyze choices made by local governments using their own resources and intergovernmental transfers from other levels of government. The limitations of this application is that in most developing countries, local resources are a small portion of local expenditures and intergovernmental transfers come with many administrative restrictions. It is difficult, therefore, to assume that the voter holds local authorities responsible for both the taxation, which is centralized, and the programs, which are only partially decentralized. Also, voters tend not to be single issue voters, they choose candidates for a variety of reasons, not just health care issues. The Social Capital Approach focuses on explaining why decentralized governments in some localities have better institutional performance than do governments of other localities. Applied to health care, this approach suggests that those localities with long and deep histories of strongly established civic organizations will have better performing decentralized governments than localities which lack these networks of associations. The weakness of this approach is that it does not provide easy policy relevant conclusions. Areas without civic networks seem to be left out of the picture and besides, it does not provide much towards understanding how national human resource for health policy interventions impact local humsn resource for health systems. In contrast, the Principal Agent Approach, outlined in Fig 2, fits the context of the Decision Space Approach and enables determination of how national human resource for health policy interventions impact local human resource for health systems through analysis of decision space, innovation and change.

The approach proposes a principal (individual or institution) with specific objectives and agents who are needed to implement activities to achieve those objectives. These agents, while they may share some of the principal's objectives, also have other (usually self-regarding) interests, such as increasing their own income or reducing the time and effort they devote to tasks for the principal. Agents also have more information about what they are doing than does the principal, giving them an advantage which could allow them to pursue

their own interests at the expense of those of the principal. The principal might like to overcome this information asymmetry, but gaining information has significant costs and may be impossible. So the principal seeks to achieve his objectives by shaping incentives for the agent that are in line with the agent's own self-interests. The principal can also use selective monitoring and punishments to encourage agents to implement activities to achieve these objectives. In addition to the information asymmetry, the principal agent approach also focuses on who controls information and how to improve monitoring. This approach allows us to view the Ministry of Health as a principal with the objectives of equity, efficiency, quality and financial soundness (rather than profit as assumed in the economic models). The local authorities are agents who are given resources to implement general policies to achieve these objectives. This approach encourages us to examine how the principal monitors performance and shapes incentives and punishments.

The Principal Agent Approach has advantages over the other approaches for developing a systematic framework for research on the decentralization of health systems in developing countries. In contrast to the local fiscal choice approach, which focuses only on the dynamics at the local level, the principal agent approach forces us to look at the relationship between the center and periphery and to see the relationship as dynamic and evolving. The approach, by focusing on the mechanisms that the center can use to shape choices at the periphery, is also appropriate for providing policy advice to authorities at the national level. It allows us to focus on determining what the national level can do to encourage local authorities to achieve the broad goals of health policy. In this context, it can be used to determine decision space, innovation and change. In this study, the approach allowed us to view the Ministry of Health and Child Care, and the Health Services Board, as actors at the Principal level. They have objectives which include equity, efficiency, quality and financial soundness (rather than profit as assumed in the economic models). The local authority (Epworth Local Board) is the Agent who is given resources to implement general policies to achieve these objectives. This approach enabled the determination of decision space between the principal, Ministry of Health, and agent, Epworth Local Board; and choices made by actors in their decision space including how the Ministry of Health shaped incentives and punishments for the Agent towards bringing about desired change.[7]

CHAPTER FOUR
THE PROBLEM AND STUDY SIGNIFICANCE

4.1 STATEMENT OF THE PROBLEM

4.1.1 The need for Human Resource for Health Reform

The need for human resource for health reform is a policy challenge undermining health sector appraisal throughout the world.[37] Prominent in this is the critical shortage of almost 4, 3 million doctors, midwives, nurses and support workers, particularly in sub-Saharan Africa.[2] This challenge undermines human resource for health policy functions which include human resource planning, budgeting, recruitment, training and development, deployment, retention, performance management and utilization, labour relations, and information systems. In turn, this undermines the availability of an adequate number of well trained, qualified, motivated, remunerated and managed healthcare workers of all categories in local health systems. Further, this also undermines improved equity, efficiency, quality and financial soundness in local human resource for health systems, and the extent to which they contribute towards health systems and policy objectives.[36-41] The healthcare worker policy challenges are particularly felt in peri-urban communities, mainly because of lack of institutional and organizational integration, and potential for health disaster in terms of disease outbreaks. [44] In addition, it is also a concern that literature of the twenty-first century does not provide a detailed narrative on human resource for health reform throughout the world. Whilst Decision Space Mapping Analysis has been used towards the health system reform agenda throughout the world, available literature does not provide a detailed narrative towards human resource for health reform.[1] It is also suggested that human resource for health reform has been overlooked in studies on health system reform throughout the world. This has contributed towards the global health workforce crisis, which has undermined health system reform as a result of an inappropriate fit between the human resource for health function and the health system appraisal.[34,35] The need for human resource for health reform has also recently emerged on the institutional agenda at the global policy level, the result ofwhich has been the First Global Forum on Human Resources for Health by the Global Health Systems Alliance from which the Kampala Declaration and Agenda for Global Action of 2008 was formulated.[3]

4.1.2 Transition to peri-urbanization and policy implications

Whilst the health policy implications of peri-urbanization are recognized in the literature, there is no detailed narrative on human resource for health reform towards health system appraisal in these communities. Yet peri-urban communities are a new form of society that exists on the fringes on urban areas of the twenty first century.[4] Peri-urbanization of the twenty-first century is characterised by an the influx of formerly urban and rural dwellers, and migrants from other countries. This influx is triggered by the negative effects of economic structural adjustment and austerity, the global financial crisis, socio-political instability and modernization. The fact that they are a often a zone of chaotic urbanization leading to sprawl and not just as a fringe in-between the city and countryside presents health implications on surrounding communities, and indeed the world at large.[4] Compounding this is the lack of institutional and organizational integration which makes them potential disaster areas in terms of disease outbreaks and health care service delivery.[5] For instance, before 2009, Epworth experienced serious Human Resource for Health Policy challenges. These challenges severely undermined the local human resource for health system functioning.

4.1.3 Sources of the problem in Epworth

4.1.3.1 Establishment, growth and status

It appeared that these challenges emanated from the establishment, status and growth Epworth as an urban fringe of the Harare of the twenty-first century, whose existence had been tolerated since its establishment as a Methodist Mission Station on a farm by Rev. Shimmin in 1890.[6] However, the large influx of people which occurred during the late 1970s and early 1980s resulted in population growth from 20 000 in 1980 to 35 000 in 1987. After the Methodist Church had transferred ownership of the farm to the Ministry of Local Government in 1983, after failing to control the influx of people, the population grew from 113 884 in 2002 to 152 116 in 2012.[6] It seemed that the continued existence was triggered by socio-economic and political factors which made life in other parts of Zimbabwe which made migration into this area inevitable. Amongst these include the Economic Structural Adjustment of the 1990s, Operation Clean up/Murambatsvina of 2005, socio-economic instability of the first nine years of the new millennium; to some extent climate change which triggered persistent droughts; and modernization of the twenty-first century.[15,47,48]

4.1.3.2 Peri-urbanization and governing health personnel

The peri-urbanization of Epworth presented a policy challenge due to semi-formal settlement, lack of planning and institutional integration, ever increasing population, the lack of basic amenities such as health facilities, which makes them potential disaster areas in terms of disease outbreaks. In a bid to contain this policy challenge, a Local Board, responsible for managing the area including the collection of rates and other levies and whose members are elected by the community, was formed in 1986 under the Urban Councils Act.[6] However, whilst the challenge of local governance had been solved by the formalization of the decentralisation process, human resource for health governance remained centralised. Some scholars have pointed out that this emanated from tendencies towards bureaucratisation and centralisation of health policy implementation in Zimbabwe. However it was alleged to result in a *de-facto* inadequate support for primary health care by the government at a local level.[16]

4.1.3.3 Unfavorable outcomes in the local human resource for health system

The local human resource for health system of Epworth before 2009 was characterised by unfavorable outcomes on Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Labour Relations; Health and Safety; and Human Resource Information and Research. This emanated from the lack of a human resource for health policy framework to provide strategic direction to effort, lack of financial and technical capacity both at the national and local level, and prominently socio-economic downturn of the first nine years of the new millennium, which peaked between 2007 and 2008.[20] Human Resources Planning and Financing had literally become non-existent due to financial incapacity which emanated from a world record-breaking rate of inflation that rendered any form of financial planning irrelevant. Compounding this was a narrow and literally non-existent revenue base for the Epworth Local Board in a highly impoverished and ever-growing community, in an ever-deteriorating health environment. The production, training and development of healthcare workers also literally became irrelevant due to the unfavorable economic situation that had resulted in braindrain of trainers to other countries, unavailability of training equipment, and mass exodus of the few trained personnel to other countries. This also undermined the deployment of an adequate number of health personnel and any effort towards their retention. As a result, there were only two clinics in the community, one Municipal and the other a Mission health facility, and a literally non-existent private healthcare sector, to provide the pool of local healthcare workers to meet

local needs. The Village Health Worker Programme largely existed on paper as basic issues such as socio-economic and political challenges of the day undermined the capacity of local community members to volunteer in health interventions. As a result, before 2007, there were only four Nurses and three Nurse Aides at the Mission clinic as outlined below:

Table 2: Health cadres in Epworth before 2007

Facility type	**Nursing staff**	**Other cadres**
Municipal clinic	**10** Registered General Nurses **3** Midwives	**2** Nurse Aides **1** Environmental Health Officer **1** Dispensary Assistant
Mission clinic	**4** Registered General Nurses	**3** Nurse Aides
Total	**17**	**7**

Fieldwork dataset

In addition, there were only 13 Nurses, 1 Environmental Health Officer and 2 Nurse Aides at the Municipal clinic. The unfavorable socio-economic situation in the country rendered labour relations irrellevent, undermined health and safety for the few healthcare workers that remained, and human resource information and research. This impacted negatively on health in Epworth, which was exposed to serious health challenges prominent of which were HIV/AIDS, TB and waterborne diseases. Preliminary inquiry revealed that between 2003 and 2007, the number of HIV cases amongst patients visiting the Municipal and Mission clinics increased dramatically. However, effort to assits them was also undermined by severe shortage of AIDS drugs, lack of equipment to test HIV, and unavailability of personnel to provide voluntary testing and counselling services. Compounding this was an outbreak of Cholera and Diarrhoea during the 2007-09 period. This was made worse by semi-structured settlement characterised by haphazard dwellings in which people constructed shallow water wells close to Blair toilets that contributed towards outbreaks of Cholera and Diarrhoea. There was also a lack of logistical equipment to facilitate the conduct outreach interventions into the community. The only Municipal clinic in the community almost closed down due to financial challenges. These unfavorable outcomes undermined human resource for health reform in Epworth peri-urban community before 2009.

4.2 SIGNIFICANCE OF THIS STUDY

Following the gaps noted in the review of the literature and the problem statement above, this study is of empirical and methodological significance.

4.2.1 Empirical Significance

4.2.1.1 Determining the impact of national human resource policy interventions in a peri-urban community

This discussion provides empirical knowledge towards understanding human resource for health reform in peri-urban communities, using Decision Space Mapping Analysis and the Decision Space Approach.[7] In this context, empirical knowledge on how the Human Resource for Health Policy of 2009 to 2014 impacted the local human resource for health system in Epworth is generated. Focus is on six result areas of human resource for health policy which include: Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Human Resource for Health Information and Research; Labour Relations; and Health and Safety. For each of these, analysis was guided by the Decision Space Approach to determine the amount of choice (Wide, Moderate or Narrow) transferred from the Ministry of Health and Child Care to Epworth's Local Board; the choices Epworth Local Board officials made with their increased range for choice, or lack thereof; and the impact that these levels of choice had towards the realization of desired Human Resource for Health Policy outcomes in this community.[7] It is envisaged that this will contribute towards the health system reform agenda through an understanding of human resource for health reform in peri-urban communities.

4.2.1.2 Reform of the Human Resource for Health Policy Function

Whilst Decision Space Mapping Analysis of the human resource for health policy function was made in studies towards health system reform, available literature does not provide a detailed narrative beyond salaries, contracts and civil service.[1] However, literature on human resource for health reform suggests the need for a more detailed narrative towards building capacity of the human resource for health policy functions.[34,35] These include: Human Resource Planning; Recruitment and deployment; Training and development; Allocation of work and supervision; Motivation and Leadership; Performance review; Labor relations; and Employee security.[40,41] Without understating the role played by finance, service organization, access rules and governance rules towards the understanding of health system reform, there is

no doubt that these are obsolete without human resources to make them functional.[7] In addition to this, it appears that the human resource for health reform agenda is built around the concept of human resource for health management, a concept which suggests more health personnel policy towards human resource for health reform of the twenty-first century. In this regard, Decision Space Mapping Analysis and the Decision Space Approach were used to determine the amount of choice transferred from the principal to the agent around the human resource for health policy functions, the choices local officials made their decision space, and effect that these choices had on the performance of the local human resource for health system in Epworth, Zimbabwe.

4.2.2 Methodological Significance

4.2.2.1 Generalization with other studies

Findings from this study may be generalised to Local Human Resource Health Systems in other peri-urban communities around the world. Peri-urbanization around the world presents common human resource health policy challenges, particularly in developing countries. These challenges include semi-formal settlement, lack of planning and institutional integration, ever increasing population, the lack of basic amenities such as health facilities and the potential for disaster in terms of disease outbreaks. Another common feature is that governments around the world are making attempts to regularise these peri-urban communities through different means. However, regardless of the means adopted, peri-urban communities in developing countries share almost similar constraints which arise out of the context surrounding their existence.[4,5]

CHAPTER FIVE
METHODOLOGY

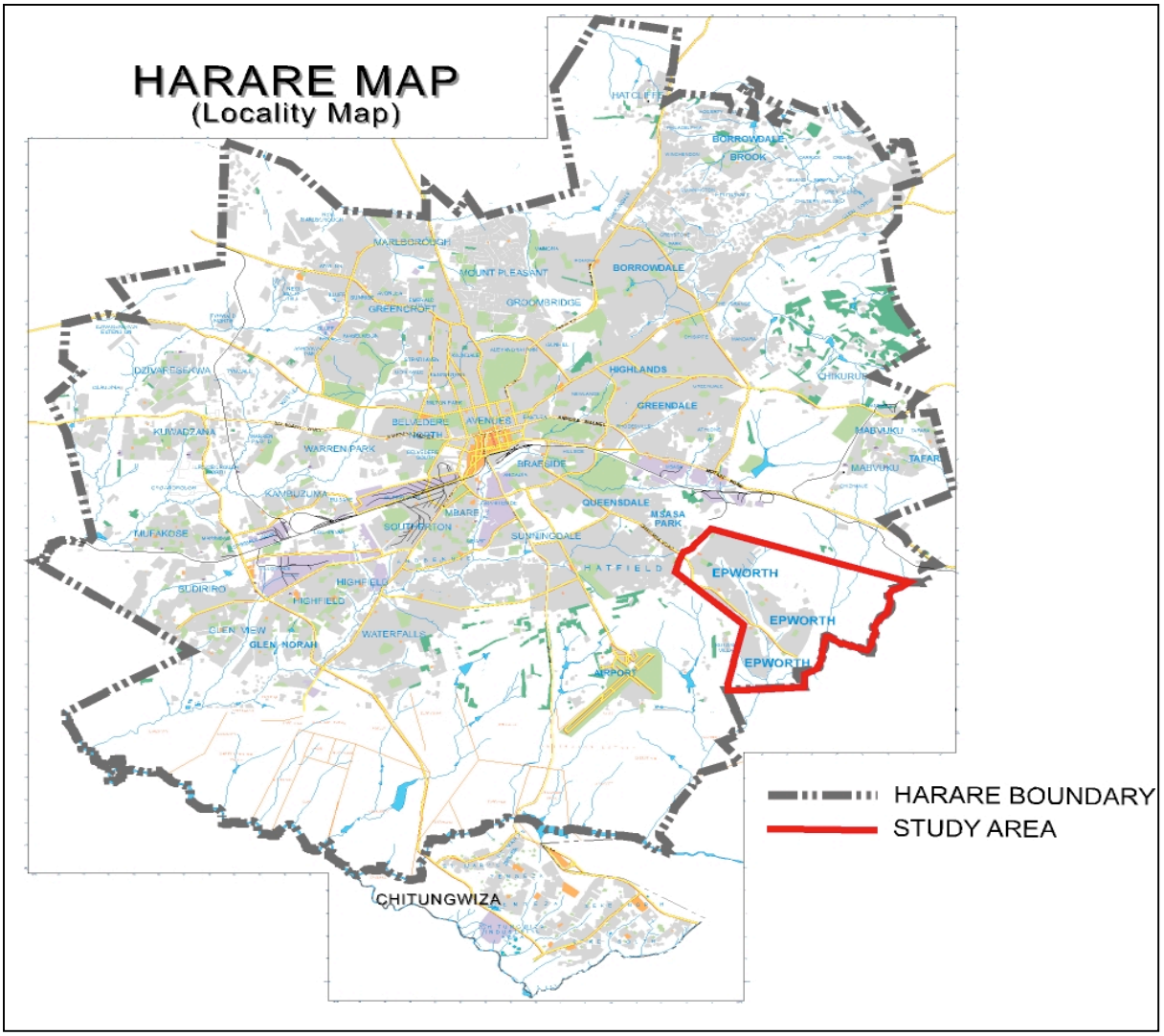
5.1 RESEARCH DESIGN

The research design was a case study design in which qualitative and quantitative methods were used in data collection, presentation and analysis.[49] The focus of the case study was on Epworth, a peri-urban community in south east Harare, Zimbabwe.

5.1.1 Study Area

The study was carried out in Epworth, a peri-urban community managed by a devolved local board.[6] It is located in the south-east edge of Harare as outlined in Fig 3 below.

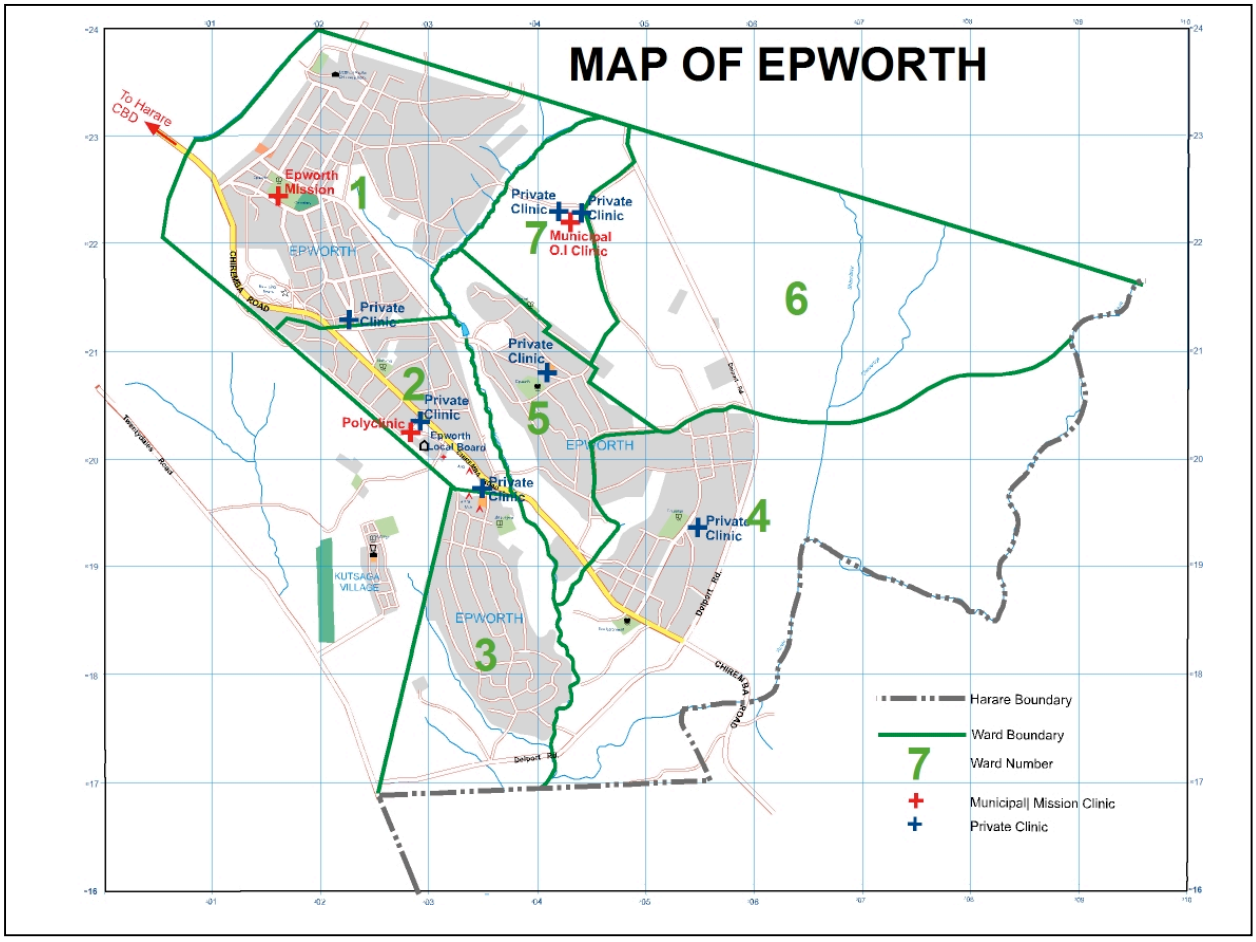
Fig 3: Map of Harare



Adapted from the Surveyor General's Office of Zimbabwe

Epworth is located fifteen kilometres south-east of Harare's city centre along Chiremba Road (Coordinates: 17' 53' 24" South; 31' 8' 51"). Epworth Local Board was formed in 1986 under the Urban Councils Act. The Local Board consists of members elected by the community, who are responsible for managing the area including the collection of municipal rates and other levies.[6] The local human resources for health system falls under the Seke Medical Dictrict of the Mashonaland East Provincial Medical Directorate of the Ministry of Health and Child Care in Zimbabwe. Epworth consists of seven wards as illustrated in Fig 4 below.

Fig 4: Map of Epworth



Adapted from the Surveyor General's Office of Zimbabwe

In these seven wards, there are seven Private clinics, two Municipal clinics and one Mission clinic. It is through these clinics that healthcare services were provided to the community between 2009 and 2014 towards addressing challenges in the local public health situation.

5.2 QUALITATIVE STUDY

5.2.1 Phase 1: Inquiry at the Principal Level

5.2.1.1 Study population, sampling procedure and key informant interviews

The Principal is the national and regional levels at which policy decision making took place.[7] Study participants at this level were drawn from the Ministry of Health and Child Care (MHCC), the Health Services Board (HSB), the Provincial Medical Directorate of Mashonaland East (PMDME), and the Seke District Medical Office (SDMO). Other participants were drawn from the Zimbabwe Association of Church Hospitals (ZACH), the Academic Community, and Nurse and Doctor Training Institutions at a national level which included the University of Zimbabwe, and Parirenyatwa School of Nursing. Key informant interviews were carried out with purposively selected policy makers to determine the human resource for health policy reform context, decision space, innovation and outcomes. Interview guides, notebooks and audio digital recorders were used. Data was collected at this level until saturation was reached. As a result, there was a total of seven key-informant interviews carried out at this level.[49,50] From the key informant interviews carried out with actors at this level, it was established that human resource for health reform in Zimbabwe was pursued through the Human Resources for Health Policy, implemented through the Human Resource for Health Strategic Plan between 2009 and 2014. Further, it was also established that effort was aimed at building capacity in policy functions that include human resource planning, budgeting and resource mobilization, recruitment, training and development, deployment, performance management, labour relations, health and safety, and human resource information systems.

5.2.1.2 Documentary search and policy analysis

The key informants referred the researcher to copies of the Human Resource for Health Policy, and the Human Resource for Health Strategic Plan of 2009 to 2014. Following a documentary search on this, an analysis of this policy revealed that the policy intervention consisted of four main result areas that included Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; and Human Resource Information and Research. Data from analysis of this policy and key informant interviews was used to develop a Human Resource for Health Decision Space Mapping Analysis conceptual tool.

5.2.2 The Conceptual Tool

This conceptual tool outlined in Table 3 consisted of six main policy result areas.

Table 3: The Human Resource for Health Decision Space Mapping Analysis Conceptual Tool

RESULT AREAS	RANGE OF CHOICE		
	Narrow[iv]	Moderate[v]	Wide[vi]
1. Human Resource Planning and Financing			
• Demand and Supply Forecasting			
• HRH Financial Budgeting			
• HRH Strategic Partnerships			
2. Production, Training and Development			
• Capacity building for training critical HRH			
• Support for further training			
• Centres of specialization			
• Induction and exchange programmes			
3. Deployment, Retention, Utilization and Management			
• Deployment			
• Retention and motivation			
• Performance management and utilization			
4. Health Labour Relations			
• Rights framework			
6 Health and Safety			
• Health welfare			
• Safety and protection			
7 Human Resource Information and Research			
• HRH Information System			
• HRH Research			

Idea adopted from Bossert.[7]

[iv] Narrow decision space is centralized decision making inwhich the principal (central government) retains all decision making power/ authority.[7]

[v] Moderate decision space is semi-decentralized decision making power/authority which is undertaken within defined regulations, parameters and conditions. It is enforced through incentives and punishments.[7]

[vi] Wide decision space is totally decentralised decision making power/ authority which is unlimited and not conditioned.[7]

These six main policy result areas included: Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Human Resource for Health Information and Research; Labour Relations; and Health and Safety. There were sub-policy functions under each of the six result areas as outlined in Table 2. For instance, human resource planning consisted of sub-policy functions that included demand and supply forecasting, strategic partnerships and budgeting. Further inquiry was then undertaken at the agent level using the Decision Space Approach around these six result areas. The objective of this was to determine three issues namely: the amount of decision space transferred from the principal (Ministry of Health and other policy community actors at the national level) to the agent (local government institutions at the periphery); Secondly, the decisions local officials made with their decision space around these six result areas; and thirdly outcomes in terms of the effect that these decisions had on the performance of the local human resource for health system in Epworth, Zimbabwe.[1] It is envisaged that this application will be adopted with adaptive modifications in similar studies on human resource for health reform towards the health system reform agenda of the twenty-first century and beyond.

5.2.2.1 Indicators used to determine decision space

For each result area, the indicators used to measure the levels of decision space (wide, moderate or narrow) included: the role and authority of actors at different levels of decision making; the political rule of the game (state's strategic interests based on political ideology); laws and regulations; administrative norms and standards; and capacity (financial, technical and human resource) to enforce decisions.[7] These indicators were incorporated into the questions asked to each category of respondents to measure decision space. These indicators of space have also been used in previous studies on this subject area. In Bolivia, Chile, Colombia, Philippines, Uganda and Zambia, they were used to determine decision space in health system functions that include Finance, Service organization, Human resources, Access rules and Governance rules.[36,37,38] In addition, these indicators were used in studies on Pakistan to determine decision space for various functions of the Health Department that included human resources management, financial management, strategic and operational planning, and service organization.[39]

5.2.3 Phase 2: Study population at the agent level

Study participants at this level were drawn from the local human resource for health system in Epworth and consisted of the Community Health Officer, Health facility managers (Sisters in Charge at public sector clinics and/or Medical Doctors at private clinics). The participants also included Nurses (Registered General Nurses, State Certified Midwives, Primary Care Nurses), Nurse-Aides, Primary Counsellors, Environmental Health Officers, Pharmacy Technicians, and Laboratory Technicians. In addition, there were also Community Health Workers (CHW) who consisted of Peer Educators, and Village Health Workers/ Community Health Volunteers, and community members.

5.2.3.1 In-depth interviews with healthcare personnel managers and sampling

In-depth interviews were carried out to determine decision space, innovation and outcomes at a health clinic level. An interview guide, notebook and digital recorder with purposively selected participants for this purpose. Data was collected until saturation was reached. From this, ten interviews were carried out.[50,51]

5.2.3.2 Focus Group Discussions and Sampling

Two Focus Group Discussions (FGDs) were carried out with Community Health Volunteers to explore the impact associated with their role. Of these, one was carried out with the Village Health Workers (VHW)/ Community Health Workers because they operated within the community whilst reporting to the two Public Clinics and one Mission Clinic. The other Focus Group Discussion was carried out with Peer Educators deployed at the two municipal clinics and mission clinic. In addition, Focus Group Discussions were conducted with purposively selected adult community members to explore service delivery outcomes towards universal health coverage. Focus Group Participants included male and female adults drawn from the local community, who have lived in Epworth before and after 2009, and have used local health facilities during the same period. Data was collected until saturation was reached. As a result, five Focus Group Discusions were carried out.

5.2.3.3 Non-participant observation

Non-participant observation was also used to collect primary data that could be used to help facilitate analysis.[50]

5.3 QUANTITATIVE STUDY AT THE AGENT LEVEL

5.3.1 Phase three: Documentary search

A documentary search was carried out at clinics in Epworth peri-urban community. Secondary data was collected from staff registers and health service files to determine outcomes that included staffing levels and numbers of health cadres at each clinic before 2009 and between 2009 and 2014. Data was also used to help determine the sampling frame and sample size.

5.3.2 Phase four: Survey interviews at the agent level and sampling frame

In addition, a survey on a sample of randomly selected healthcare workers (cadres of healthcare) was carried out at clinics across Epworth. For this purpose, a semi structured questionnaire was used.[50] The sampling frame for these healthcare workers consisted of two main categories of health cadres namely medical and non medical personnel. The medical personnel were Nurses (Registered General Nurses, State Certified Midwives, and Primary Care Nurses). The non medical personnel were other health cadres who facilitate the provision of healthcare in different capacities. These included Nurse-Aides, Primary Counsellors, Environmental Health Officers, Pharmacy Technicians, Laboratory Technicians and Ambulance Drivers.

Preliminary inquiry from staff registers revealed that there was a total of 101 health workers of all cadres, excluding Medical Doctors and Sisters in Charge at health facilities across Epworth. This information was obtained from staff registers (staff roster) following a preliminary inquiry into the staff establishment at each facility in Epworth. A summary of the staff establishment is outlined in Table 4 below. In this table, it is illustrated that the Mission clinic had 15 health cadres, but there were no Medical Doctor at this facility. Two Municipal clinics in this community had a combined number of 63 healthcare workers, 42 of whom were at one of them, and there were no Medical Doctors at these facilities. Private clinics in this area had a combined total of 38 healthcare workers, and 7 General Medical Practitioners (Medical Doctors) in total.

Table 4: Staff establishment at health facilities in Epworth

Facility Type	Human Resource for Health Managers	Nursing staff	Other cadres	Total for all cadres (excluding Medical Doctors and Sisters in Charge)
Mission clinic	**1** Sister in Charge	**2** Primary Counsellors; **6** Registered General Nurses; and **2** Primary Care Nurses.	**1** Environmental Health Officer/ Technician; and **4** Nurse Aides.	**15**
Municipal "Polyclinic" clinic	**1** Sister in Charge	**11** Registered General Nurses; **6** Midwives; **1** State Certified Nurse; **3** Primary Care Nurses; **2** Primary Counsellors.	**1** Pharmacy Technician; **3** Laboratory Scientists; **3** Ambulance Drivers; and **1** Environmental Health Officer; **11** Nurse Aides.	**42**
Municipal "OI" clinic	**1** Sister in Charge	**13** Registered General Nurses.	**1** Dispensary Assistant; **1** Environmental Technician; **5** Nurse Aides; and **1** Pharmacy Technician.	**21**
Private clinic	**1** General Practitioner.	**1** Registered General Nurse; **1** Primary Care Nurse.	**2** Nurse Aides.	**4**
Private clinic	**1** General Practitioner.	**1** Registered General Nurse.	**3** Nurse Aides; **1** Lab Pathologist; **1** Radiologist; **1** Dental Surgeon.	**7**
Private clinic	**1** General Practitioner.	**1** Registered General Nurse; **1** Midwife.	**2** Nurse Aides.	**4**
Private clinic	**1** General Practitioner.	**2** Registered General Nurses.	**1** Nurse Aide.	**3**
Private clinic	**1** General Medical Practitioner	**1** Primary Care Nurse.	**0**	**1**
Private clinic	**1** General Practitioner.	**2** Registered General Nurses.	**0**	**2**
Private clinic	**1** General Practitioner		**2** Nurse Aides	**2**
Total		**56**	**45**	**101**

Data generated from staff registers at local clinics

The total study population in this case was 101 health workers. It is from this total population that the sample size was determined using the formula as explained below.

5.3.2.1 Sample size determination formula

Given that the total population of 101 (from the health staff registers), the sample size was determined through the following formula:[52]

$$SS = \frac{Z^2 p(1-p)}{c^2}$$

Where:

SS=Sample size

Z = Z value (e.g. 1.96 for 95% confidence level)

p = percentage of the performance

c = confidence interval, expressed as decimal (e.g., .04 = ±4)

Pop=Population

Using the formula above, the answer was 87. Therefore 87 is the total sample size constituting the total number of interviews carried out with healthcare workers. However, in order to determine the actual persons interviewed, the proportionate distribution of health workers between health facilities was considered towards determining the total number of interviews to be carried out at each facility. In other words, sampling was proportional to size.

For this purpose, Table 5 below outlines the distribution of health workers and the proportionate distribution of sample sizes for each facility. The proportion were arrived at by dividing the total number of health personnel at each clinic with the total population of 101 of all health workers at clinics in Epworth. As illustrated in this table, 13 interviews were carried the private not for profit clinic, 18 at one public clinic, 3 at a private for profit clinic, and 3 at another private for profit clinic. 4 interviews were carried out at another private for profit clinic, 3 at the other in a different location, 1 another private for profit clinic, 37 at public clinic, and 1 each at two different private clinics.

Table 5: Proportionate distribution of health workers by facility

Facility Type	Nursing staff	Other cadres	Total for all cadres (excluding Medical Doctors and Sisters in Charge)	Proportion of the total sample size of 87	Total number of interviews
Mission clinic	**2** Primary Counsellors; **6** Registered General Nurses; and **2** Primary Care Nurses.	**1** Environmental Health Officer/ Technician; **4** Nurse Aides;	**15**	**15%**	**13**
Municipal "Polyclinic" clinic	**11** Registered General Nurses; **6** Midwives; **1** State Certified Nurse; **3** Primary Care Nurses; **2** Primary Counsellors.	**1** Pharmacy Technician; **3** Laboratory Scientists; **3** Ambulance Drivers; **1** Environmental Health Officer; **11** Nurse Aides	**42**	**42%**	**37**
Municipal "OI" clinic	**13** Registered General Nurses.	**1** Dispensary Assistant; **1** Environmental Technician; **1** Pharmacy Technician **5** Nurse Aides.	**21**	**21%**	**18**
Private clinic	**1** Registered General Nurse; **1** Primary Care Nurse.	**2** Nurse Aides.	**4**	**3%**	**3**
Private clinic	**1** Registered General Nurse.	**3** Nurse Aides; **1** Lab Technician; **1** Radiologist; **1** Dental Surgeon.	**7**	**7%**	**6**
Private clinic	**1** Registered General Nurse; **1** Midwife.	**2** Nurse Aides.	**4**	**4%**	**4**
Private clinic	**2** Registered General Nurses.	**1** Nurse Aide.	**3**	**3%**	**3**
Private clinic	**1** Primary Care Nurse.	**0**	**1**	**1%**	**1**
Private clinic	**2** Registered General Nurses.	**0**	**2**	**2%**	**1**
Private clinic		**2** Nurse Aides	**2**	**2%**	**1**
Total	**56**	**45**	**101**		**87**

Data generated from staff registers at local clinics

At each facility, the number of interviews was proportionately determined for each category of health cadres at each health facility as illustrated in Table 6 below.

Table 6: Proportionate distribution of interviews by health worker category at each facility

Facility type	**Medical nursing staff and number of interviews**	**Other cadres and number of interviews**
Mission clinic	**6** Registered General Nurses **(5 interviews)**; and **2** Primary Care Nurses **(2 interviews)**.	**1** Environmental Health Officer/ Technician **(1 interview)**; **2** Primary Counsellors **(2 interviews)**; and **4** Nurse Aides **(3 interviews)**;
Municipal "Polyclinic" clinic	**11** Registered General Nurses **(10 interviews)**; **6** Midwives **(5 interviews)**; **1** State Certified Nurse **(1 interview)**; and **3** Primary Care Nurses **(2 interviews)**.	**1** Pharmacy Technician **(1 interview)**; **3** Laboratory Scientists **(3 interviews)**; **3** Ambulance Drivers **(3 interviews)**; **1** Environmental Health Officer **(1 interview)**; **11** Nurse Aides **(10 interviews)**; **2** Primary Counsellors **(2 interviews)**.
Municipal "OI" clinic	**13** Registered General Nurses **(12 interviews)**.	**1** Dispensary Assistant **(1 interview)**; **1** Environmental Technician **(1 interview)**; **1** Pharmacy Technician **(1 interview); 5** Nurse Aides **(3 interview)**.
Private clinic	**1** Registered General Nurse **(1 interview)**; **1** Primary Care Nurse **(1 interview)**;	**2** Nurse Aides **(1 interview)**.
Private clinic	**1** Registered General Nurse **(1 interview);** **1** Dental Surgeon **(1 interview)**.	**3** Nurse Aides **(2 interview)**; **1** Lab Technician **(1 interview); 1** Radiologist **(0 interview)**
Private clinic	**1** Registered General Nurse **(1 interview)**; **1** Midwife **(1 interview)**.	**2** Nurse Aides **(2 interview)**.
Private clinic	**2** Registered General Nurse **(2 interviews)**;	**1** Nurse Aide **(1 interview)**.
Private clinic	**1** Primary Care Nurse **(1 interview)**.	**0**
Private clinic	**2** Registered General Nurses **(1 interview)**.	**0**
Private clinic		**2** Nurse Aides **(1 interview).**
Total	**47**	**40**

Data generated from staff registers at local clinics

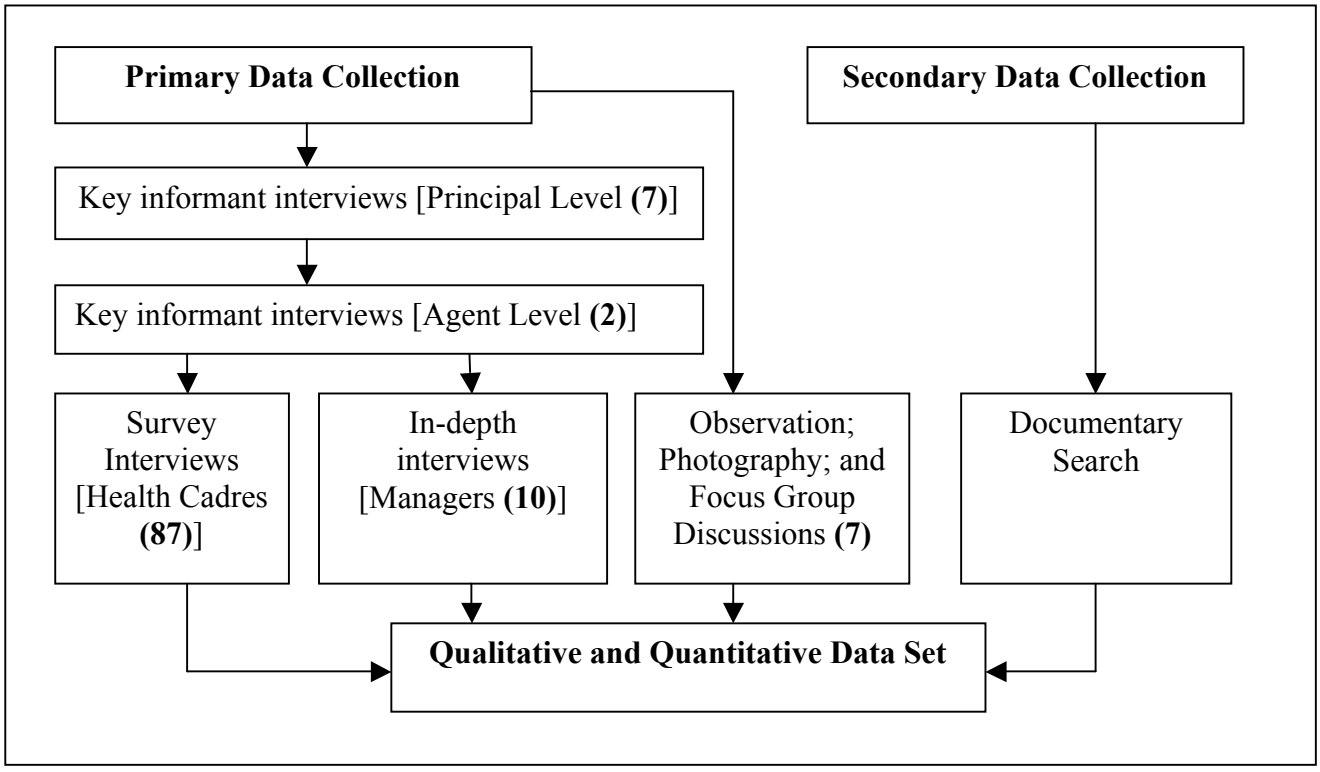
In Table 6 above, 47 interviews were carried out with medical nursing staff whilst 40 interviews were conducted with non-medical nursing and support staff. Of the total 87

interviews, 69 were carried were carried out with healthcare workers from the public sector. 37 of these were medical nursing staff whilst 32 were carried out with non-medical support staff.

5.3.3 Summary of the data collection plan

The summary of the data collection plan is outlined in Fig 5.

Fig 5: Summary of data collection plan



Source: Fieldwork datatset

Seven key informant interviews were carried out at the Principal Level with National and Regional Policy Actors. One key informant interviews was carried out with the Agent Level Policy Actor and ten in-depth interviews were carried out with Human Resource for Health Managers (Doctors and/or Sisters in Charge) at health facilities across the community. Survey interviews were carried out with a random sample of 87 Health Cadres drawn from amongst Primary Counsellors, Nurse Aides, Primary Care Nurses, Registered General Nurses, Clinical Officers, State Certified Nurses, Environmental Health Officers, Pharmacy Technicians, Dispensary Assistants, Dental Surgeons, Laboratory Scientists and Ambulance Drivers. Seven Focus Group Discussions were also carried out with community members.

5.4 DATA PRESENTATION METHODS

5.4.1 Qualitative data

Qualitative data was transcribed, coded and presented in narrative form. The codes were developed for each of the six result areas of human resource for health policy.[49,50] Under each, there was a narration of decision making authority and roles, innovations and outcomes/changes in Epworth peri-urban community before and during the implementation of the Human Resource for Health Policy of 2009 to 2014. The six main result areas included: Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Human Resource for Health Information and Research; Labour Relations; and Health and Safety.

5.4.2 Quantitative data

Data on policy outcomes in each coded result area of human resource for health policy was tabulated. Tables were developed for outcomes/changes in areas that included staffing levels, sector contributions towards human resources for health, doctor to patient ratios outcomes from HIV/AIDS interventions, and benefits allocated to healthcare workers in Epworth peri-urban community.

5.5 DATA ANALYSIS METHODS

5.5.1 Decision space mapping analysis

In each of the six coded policy result areas, the Decision Space Approach was used to determine decision space (narrow, moderate or wide). Decision space for each of the sub-policy functions under each of the six main policy result areas was then mapped onto the Human Resource for Health Decision Space Mapping Analysis Application. Apart from facilitating the determination of decision space, the Decision Space Approach was also used to determine innovation and outcomes/changes in each of the six result areas of human resource for health policy implemented in Epworth peri-urban community between 2009 and 2014.

5.5.2 Descriptive statistical analysis

Descriptive statistics were used to interpret outcomes/changes as a result of decision space and innovations in each of the six result areas during the implementation of the human

resource for health policy. Bar graphs, line graphs, means and ratios were used to analyse data on aspect that included staffing levels, sector contributions towards human resources for health, doctor to patient ratios, service outcomes from HIV/AIDS interventions, and the proportion of benefits allocated to healthcare workers.[50,51]

5.5.3 Triangulation

Qualitiative and quantitative data were integrated during presentation and analysis where necessary. Integration was done to facilitate cross-verification and interpretation of data on aspects that included staffing levels, sector contributions towards human resources for health, doctor to patient ratios, service outcomes from HIV/AIDS interventions, and the proportion of benefits allocated to healthcare workers.

5.6 AUTHORIZATION AND ETHICAL CLEARANCE

5.6.1 Institutional approval

This research received authorization from the Ministry of Health and Child Care of Zimbabwe, Health Services Board, Mashonaland East Provincial Medical Directorate, Seke District Medical Office, Epworth Local Board and Zimbabwe Republic Police. It was also approved by the Academic Advisory Committee (AAC) of the University of Pretoria. The research received prior ethical approval from the Research Ethics Committee (REC) of the Faculty of Health Sciences, University of Pretoria (Reference number 413/2014). After this, ethical approval was granted by the Medical Research Council of Zimbabwe (Approval Number MRCZ/A/1941).

5.6.2 Informed consent

Informed consent and permission to participate was sought from each participant through an Informed Consent Form.[49] Informed consent was also sought for each interview audio, and video recorded, and for which photographs were obtained. For each participant, the researcher read out the content of the consent form before addressing questions that they might have about the study after which they were asked to to provide informed consent by signing. From this, all participants provided informed consent to participate in the study. Participation by the subjects was voluntary and participants had the right to refuse or stop themselves from taking part. The privacy and confidentiality of participants and organizations

was upheld throughout and beyond the study.[49] Their names, identities, personal data and the names of their organizations will be kept anonymous throughout and beyond this study.

5.6.3 Potential harms and benefits

All participants were informed about the potential benefits of the study through informed consent forms.[50] Prior arrangements were made with each participant before each interviews to avoid interfering with their work schedule. Participants were also informed that they were not obliged to answer certain questions that they were not comfortable with due consideration to the socio-political environment in Zimbabwe.

5.6.4 Reporting of findings

Findings have already generated one article published by the Biomedcentral Journal of Human Resources for Health. Other findings will be used to generate high impact research articles for publication in international refereed research journals. A report will be prepared and submitted to give feedback to the Epworth Local Board, Ministry of Health and Child Care of Zimbabwe (MoHCC), and the Health Services Board (HSB) of Zimbabwe. In addition, results of this study will be shared with the African Population and Health Research Centre (APHRC), International Development Research Centre (IDRC), and Faculty of Health Sciences at the University of Pretoria. Other ways of reporting the research findings to have practical policy and action impacts will also be collaboratively sought in discussion with stakeholders involved in this study.

5.6.5 Limitations

There was a potential challenge of recall bias amongst some of the respondents. The process of avoiding bias entailed the proper definition and articulation of research question, determining the most appropriate method to collect the information and collecting data from each category of respondents until saturation was reaching. Further, there was cross verification of data on a similar aspect but from different respondents in the same category to identify consistencies, inconsistencies and completeness and incompleteness in the dataset.

5.6.6 Data Management and Research Team

An audit trail was compiled against which a list of all the research material is being recorded and kept secure in a locked database inside the researcher's personal laptops, and external

hard drive which are password protected. Hard files with back up information and study material are being kept in a locked and secure safe at the researcher's home. One enumerator was recruited to assist in data collection. The enumerator was trained on how to interpret the data collection tools, sample participants, use the digital voice recorder, and fieldwork logistics. In addition, a statistician was also engaged to help in statistical analysis. Each was paid an allowance to cover their transport, and meals. A token of appreciation was also paid to each for their participation.

CHAPTER SIX
PRESENTATION OF FINDINGS

6.1 SUMMATIVE PROFILE OF STUDY PARTICIPANTS

Seven key informant interviews were carried out with principal level study participants and one agent level participant, from whom qualitative data was collected.[47] This is outlined in Table 7 below.

Table 7: Summative Profile of Study Participants

Category of participant	Level of decision making	Type of data	Number of interviews
Key informants	Principal	Qualitative	7
Key informants	Agent	Qualitative	1
In-depth interviewees	Agent	Qualitative	10
Sample respondents	Agent	Quantitative	87
Focus Group Participants	Agent	Qualitative	70

Source: Fieldwork dataset

Principal level participants were drawn from the Ministry of Health and Child Care (MHCC), the Health Services Board (HSB), the Provincial Medical Directorate of Mashonaland East (PMDME), and the Seke District Medical Office (SDMO). Other participants were drawn from the Zimbabwe Association of Church Hospitals (ZACH), the Academic Community, University of Zimbabwe, and Parirenyatwa School of Nursing. One key informant interview was carried out with the Community Health Officer of Epworth because all potential partcipants refered the researcher to them. Ten in-depth interviews were carried out with health facility managers. Of these, three interviews were carried out with Sisters in Charge at two Municipal clinics and one Mission clinic. The other seven interviews were carried out with Medical Doctors/Owners at private clinics. Quantitative data was collected from a sample of 47 Medical Personnel (Registered General Nurses, State Certified Midwives, Primary Care Nurses), and 40 Non-medical personnel (Nurse-Aides, Primary Counsellors, Environmental Health Officers, Pharmacy Technicians, and Laboratory Technicians). In addition, there were also two Focus Group Discussions (FGDs) with Community Health

Volunteers (CHV). Of these, one was carried out with Peer Educators, and the other with Village Health Workers and/or Community Health Workers. Five Focus Group Discussions were also carried out with community members.

6.2 AN OVERVIEW OF THE LOCAL HEALTH SITUATION IN EPWORTH

6.2.1 Immigration and unplanned settlement

It was established that Epworth is characterized by unplanned and haphazard settlement in almost all parts of the community. In this, settlement occurred on land without any water supply and sanitation facilities.[6] This emanates from a history of immigration which may be traced back to 1890 when Epworth Mission was established on a farm as a Methodist Mission Station. Over the years however, the area expanded due to a large influx of people which occurred during the late 1970s and early 1980s. The Methodist Church could not control the influx of people, and therefore transferred ownership of the farm to the Ministry of Local Government in 1983.[6] Increased cost of living in Harare, and the perceived lack of socio-economic opportunities in rural areas of Zimbabwe associated with the aftermath of the Economic Structural Adjustment Programme of 1992, Operation Clean up of 2005, climate change and socio-economic crisis in Zimbabwe which peaked between 2007 and 2008 has resulted in a continued immigration by people into this community. In the post 2009 era, it was established that immigration into Epworth has been driven by: lower cost of living, particularly rentals, in the face of an increased in the cost of living in other parts of Harare; a shrinking private sector characterized by company closures and retrenchments; and perceived economic opportunities in the city's informal sector, in this city, all associated with the use of the United States Dollar.[45,46] As a result, Epworth became the only informal settlement to have been allowed to continue by the Zimbabwean Government in the post-independence period because of the long history of settlement by most of the residents. The government decided to upgrade rather than demolish the informal settlement. However, it had not been planned as an urban residential area which presents more challenges.

6.2.2 Lack of public utilities

Since most residents of Epworth had settled in the area spontaneously, public utilities such as water, sewage and electricity are not available in most parts of the community.[6] As a result, it was established that people construct Blair toilets and unprotected water wells at their housing units. However, this is contributing towards increasing cases of diarrhea outbreaks

because of poor water and sanitation emanating from exposure of the unprotected water wells to seepage of waste from Blair toilets which in most cases were constructed near them. It was established from the Environmental Health Technicians interviewed reported that analysis of water from the unprotected wells, by the government and private research consultants, revealed that it was not suitable for human consumption as it contained faecal matter. From this research, it was recommended that the local community members should make use of the boreholes in the community to meet their water needs. However the boreholes are few and far in between from some households which also present another set of challenges. In addition to this, it was also established that unplanned settlement presents challenges in tracing patients and follow-up to deliver health interventions to community members.

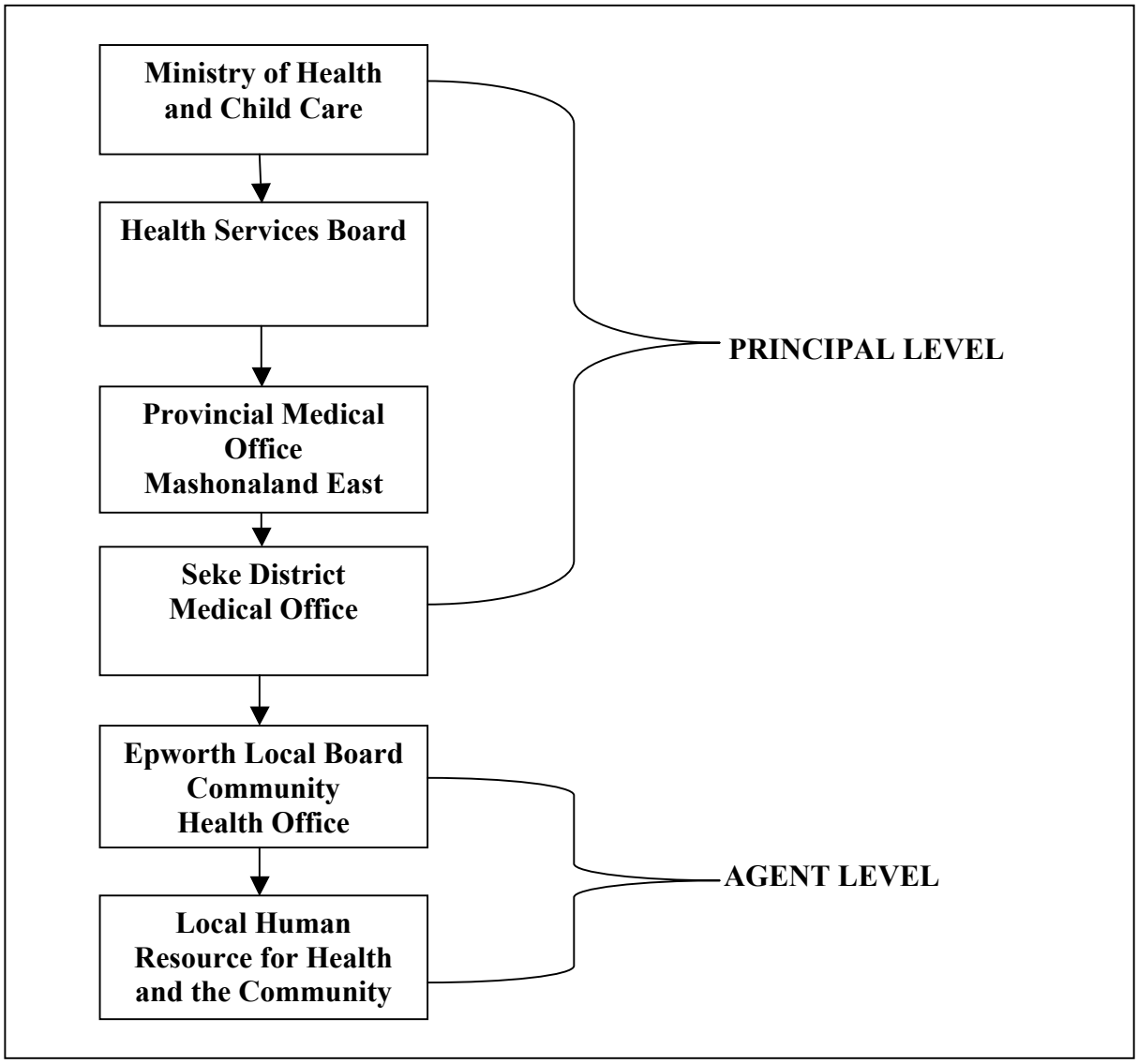
6.2.3 Communicable diseases

The community is also exposed to communicable diseases the most frequent of which are HIV/AIDS, Multi-Drug Resistant Tuberculosis (MDRTB), Malaria and Sexually Transmitted Infections (STIs). It was established that HIV/AIDS is on the increase in this community. It was established that poverty was the driver behind this increase as it fuels Sex Work (SW). Inquiry established that Sex Work has become a source of livelihood for most who transact either US$ 1 or ZAR 5 Rand for sex at places of interaction, the most common of which is a place called the “Booster,” a location somewhere in the community which typifies areas where prostitution takes place. HIV/AIDS is also triggering outbreaks of STIs, and Tuberculosis. Of concern however are cases of MDRTB which were said to be on the increase in this community. It was established that investigations by the health officials in this community suggested that it appears as though MDRTB is imported from neighboring countries mainly South Africa, as people who suffer from it are frequent either frequent travelers or infected relatives of frequent travelers to that country, mainly engaged in cross border trading. In addition, it was also established from Environmental Health Technicians interviewed that cases of imported malaria were on the increase in this community. It was suggested that this malaria was being imported from Mozambique, where some locals go to import second hand clothes for resale.

6.3 ORGANIZATION AND DECISION MAKING LEVELS

It was established that decision making was undertaked at two levels namely the Principal and Agent, as outlined in Fig 6 below.

Fig 6: The Organizational Structure and Decision Making Levels



Fieldwork dataset

6.3.1 Principal level actors

6.3.1.1 National and Provincial Actors

Decision actors at this level included the Ministry of Health and Child Care (MoHCC), and the Health Services Board (HSB). It was also established that the Provincial Medical Office of Mashonaland East (PMOME) was part of the National Human Resource for Health

Taskforce (HRHT). This taskforce was also made up of representatives from Ministries and organizations were the other actors at this level. The decision role of actors was to formulate, support, regulate, supervise and monitor the policy implementation process. One of the key roles of the Ministry of Health at this level was to collaborate with the Ministry of Finance and Economic Development (MFED) for financial support. Apart from this, the Health Services Board through the Ministry of Health and Child Care also collaborated with the Ministry of Higher and Tertiary Education (MHTE) which was responsible for the production of medical practitioners, the Zimbabwe Association of Church Hospitals, the Health Professions Authority (HPA) and Health Professions Councils (HPC). The Provincial Medical Office of Mashonaland East (PMOME) was responsible for planning, monitoring and evaluation of the health services in the province. The PMOME served as an extended administrative arm of the ministry's head office and was responsible for budgetary allocations to the Seke District Medical Office (SDMO). It is worth noting that the Provincial and Dictrict Medical Offices were administrative offices created through the process of *deconcentration*.

6.3.1.2 District actors

The SDMO represented the PMOME at a district level. It consisted of the Seke District Health Executive (SDHE) made up of the Seke District Medical Officer, Seke District Nursing Officer, Seke District Pharmacist, Seke District Health Service Administrator and the Seke District Environmental Health Officer. In addition, the Seke District Health Management Team (SDHMT) comprised of the five SDHE members plus the chairperson of the Health Committee of the Seke Rural District Council (SRDC), the SRDC Executive Officer for Health, the District Administration, Community Health Office and representatives of all health institutions (Sisters in Charge), including the missions in Seke District. The SDHMT had the task to supervise all health facilities in the Epworth Local Board municipal/council, mission and private clinics.

6.3.2 The agent level and local actors in the reform process

6.3.2.1 Epworth Local Board

It constituted the Local Human Resource for Health System through which policy of between 2009 and 2014 was implemented. The local board was the municipal authority created through a process of *devolution*. However, capacity constraints (technical, financial, human

resource and material resource) because of the context surrounding the existence of this peri-urban community and the socio-economic challenges of pre 2009 undermined the functioning of the local board towards human resource for health. As a result, between 2009 and 2014, the Ministry of Health intervened through its Provincial and District Medical Offices through the process of *deconcentration* towards human resource for health reform. In this context, the Seke District Medical Office, a deconcentrated arm of the Health Ministry, supervised municipal (Local Board) health staff deployed at the two Municipal clinics in Epworth, and healthcare workers employed by the Methodist Mission, working at their clinic in this community. This is because their salaries were paid by the government through the Ministry of Health and Child Care. The Local Board had ownership of the two Municipal clinics. However, between 2009 and 2014, they also received supervisory authority supervisory assistance directly from the Ministry of Health and Child Care through the Seke District Medical Office and indirectly through a collaborative partnership between the Ministry of Health and an international NGO through which the government intervened by way of a TB and HIV/AIDS Programme. One of these two Municipal clinics generally specialised in Opportunistic Infections (OIs) whilst the other was a Polyclinic, specialising in maternal and child care. In addition however, both facilities provided primary care services to the community. With the exception of private clinics and the international NGO, the staff establishment at the three facilities (two Municipal clinics and one Mission clinic) consisted of a Sister in Charge, a qualified nurse with specialist midwifery training. In addition, there were medical health cadres who included Registered General Nurses, State Certified Nurses, Midwives and Primary Care Nurses. There were also non-medical staff who included Environmental Health Officers, Pharmacy Technicians, Laboratory Technicians and Nurse Aids. These cadres were supported by a network of Community Health Volunteers (CHV) who consisted of Peer Educators, who assisted service provision at the clinics, and Village Health Workers (directly trained by the Ministry of Health itself) and Community Health Workers (indirectly trained by the Ministry of Health through the aforementioned international Non Governmental Organization).

6.3.2.2 The local private for profit and non-profit sector

Parallel to these were seven private clinics operated by individual General Medical Practitioners who provided similar health services. These were smaller facilities located at shopping centres across the community. The staff complement at each of these facilities

generally included a General Medical Practitioner, who would provide medical services at fixed hours of the day, assisted either by a Registered General Nurse and/or a Nurse Aid, who would provide basic primary care services in the absence of the General Medical Practitioner for the rest of the operating hours of the day. Private clinics were governed by an operating licence awarded by the Local Board and a Code of Conduct from the Ministry of Health and Child Care. However, their status and financial status meant that they enjoyed wider decision space in the implementation of healthcare policy interventions.

6.4 DECISION MAKING AUTHORITY AND POLICY OUTCOMES

6.4.1 Result area one: Human Resource Planning and budgeting

6.4.1.1 Decision making on human resource planning

The policy aim in this result area was to attain at least a balance in demand and supply forecasting of health personnel. In Epworth, it was established that human resource planning was undertaken through complementary effort by the Epworth Local Board, and the Ministry of Health. In this, there was a shared responsibility effected through dialogue between the Local Board and Ministry of Health towards projecting the demand and supply of health personnel for the two Municipal clinics and one Mission clinic in Epworth. Intervention by the Ministry of Health on this policy area was necessitated by the Epworth Local Board's lack of technical and financial capacity. Lack of capacity emanated from a narrow revenue base, lack of technical expertise and the negative effect of socio-economic challenges of 2007-08. Apart from this were peculiar circumstances surrounding the existence of this peri-urban community which included semi-formal settlement, an ever-increasing impoverished population, overwhelming disease burden, and the crippling effect of an unfavourable macro-economic situation pre 2009. Equally important was the need by the Ministry of Health to ensure implementation of the 2009 Human Resource for Health Policy towards reform. As a result, the Ministry of Health played a bigger role, mainly through its Provincial and District Medical Offices, towards determining the number and potential sources of health cadres with the kinds of skills, knowledge and attitudes required. The District Medical Office made regular inquiries into the staff establishment at each of the three clinics, and capacity to meet requirements by the Local Board before making recommendations to the Provincial Medical Office. In turn, the Provincial Medical Office reviewed the recommendations and advised the Ministry of Health about the HRH situation in Epworth. The Ministry of Health would, if need be and/or situation permitting, engage its National Taskforce, predominantly the

Ministry of Finance to supply funding for the healthcare workers required. In the event that the Ministry of Finance did not have the financial resources, was incapacitated, then consultations would be made at the principal level with the donor community in the context of ZUNDAF.

It appeared that collaborative effort by these actors impacted somewhat positively on the local human resources for health system. To start with, human resource planning, which had literally ceased in the midst of the socio-economic challenges of pre 2009, became functional again. This somewhat contributed towards reducing the gap between the demand and supply of healthcare workers at the two municipal clinics and private clinic between 2009 and 2014. The arrangement for local private sector was different to that of the local public sector. Private clinics were guided by their financial capacity towards estimating the number of professionals and the kinds of skills, knowledge and attitudes required, and their potential sources. However, it was established that their capacity was limited by a narrow revenue base because of fewer clients in an impoverished community whose majority could not afford private medical care, and opted to use the local public sector where the cost of medical care was lower, and prospects for free medical care greater. It appeared that this accounted for the smaller size and operational functions of private clinics.

6.4.1.2 Budgeting

There were complementary budget structures between the Local Board, the Health Ministry, and Mission. Whilst the Epworth Local Board was a devolved local municipal authority with its own budget, it was established that this budget was insufficient to meet financial needs of all healthcare workers as it could only meet salaries for only two Nurses, two Nurse Aids and four Security Guards and sundries to support health personnel. As a result, the Ministry of Health intervened to pay salaries of rest of the 88 healthcare workers at the two local municipal clinics and one mission clinic from its share of the national budget whilst the local board and mission complemented this effort through the payment of top-up allowances to the majority of these workers. A documentary search into expenditure from the share of annual budget by the Epworth Local Board revealed that there was an increase in the proportion allocated towards health personnel from 21% to 45%.

It was established that the proportionate increase in expenditure by the Epworth Local Board was necessitated by the gradual withdrawal of NGO funding in 2013, and the deployment of more health personnel at the two Municipal clinics. Key enabling factors included the introduction of a multicurrency regime by the Government of Zimbabwe in 2009, in which the United States Dollar was the main currency. This brought stability and certainty that enabled the Epworth Local Board to gradually expand its local revenue base between 2009 and 2014. From this, the local board expanded the revenue base through the sale of formal residential stands in one part of the community, where new residential and business stands were being allocated. In addition, revenue was also collected from the rates from individual housing units and taxes from local enterprises throughout the community. This enabled the Local Board to pay top-up allowances to health personnel at these two clinics. However, it is worth noting that despite the increases, the local budget remained inadequate to meet salaries for all health personnel at these two clinics. This was attributed to a narrow local revenue base, impoverishment, immigration, semi-formal settlement and other competing local policy priorities. As a result, the Local Board remained dependent on the Ministry of Health for the payment of salaries. On the other side, the mission in Epworth had its own budget from which it paid top-up allowances to help supplement salaries that were being paid by the Ministry of Health. However, it was established that the mission was constrained as it only managed to pay top-up allowances for only four Nurses, four Nurse Aides and one Environmental Health Officer who had worked at its clinic before 2009.[6] As a result, the other four Nurses deployed by the Ministry of Health to help complement the local staff establishment at the Mission clinic after 2009 did not receive any top-up allowances. This was further compounded by the failure to provide all sundries required to support health personnel at its clinic between 2009 and 2014. Health personnel at the Mission clinic raised their concern over the withdrawal of certain sundries that had provided before. On this one stated the following:

"Our Mission used to provide us washing soap but they have since stopped. As a result we now have to bring our own soap from home and that is very difficult for us given our low salaries. However, there is nothing one can do about it because work has to be done at the end of the day."

For the Ministry of Health, formulation of the healthcare worker budget was centralised and done in consultation with the Ministry of Health Taskforce that also included the national Treasury. From this, it was etsblished that the proportion of expenditure on health from share of national budget was 8, 56% in 2006, as outlined in Table 8 below.

Table 8: Proportion of expenditure from share of national budget

	Proportion of expenditure from share of National Budget					
Year	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Expenditure	8, 56%	8, 58%	9, 33%	8, 64%	10%	12, 7%

Adapted from Ministry of Finance and Economic Development[53-59]

This proportion increased slightly to 8, 58% in 2010, and further to 9, 33% in 2011 before a decrease to 8, 64% in 2012. There was however an upward trend to 10% in 2013, and 12, 7% in 2014.[49-55] Further inquiry to account for the proportions of expenditure on health from share of national budget revealed that the principal experienced a combination of financial constrains and competing cost-cutting macro-economic policy interventions defined in the Staff Monitored Programme by the Government and the International Monetary Fund (IMF). As a result, there was the freezing of public health sector recruitment whist only allowing some limited flexibility in filling critical vacancies that could not be filled through internal mobility so as to avoid expanding expenditure.[60] In practice, this seemed to undermine the ability to supply funding for more healthcare workers in Epworth, the effect of which was inadequate numbers of healthcare workers at Municipal clinics and the Mission clinic, which depended on the government for healthcare worker funding. In addition, it also seemed to contribute towards perceived inadequate remuneration for healthcare workers employed by these organizations which also undermined healthcare worker morale. In a bid to overcome these financial and technical constraints, the Ministry of Health used its space to innovate by engaging its international Human Resource for Health Strategic Partners in the context of the Zimbabwe United Nations Development Assistance Framework (ZUNDAF). As a result, it entered into a strategic partnership which facilitated a programme specific intervention on TB and HIV/AIDS by an international Non Governmental Organization (NGO) in Epworth.

6.4.1.3 Decision authority and outcomes on international strategic partnerships

Strategic partnerships were an intervention meant to mobilise financial and technical resources towards complementing government effort in the implementation of the 2009 Human Resources for Health Policy. Between 2009 and 2014, they were also a source of temporary relief aid which facilitated the resuscitation of the local human resource for health system. The decision making authority on this aspect was made at the principal level by the Ministry of Health in consultation with the Ministry of Foreign Affairs as stated by one key informant at a principal level as follows:

"The Ministry of Health through the Health Services Board played the role of identifying and establishing strategic partnerships with national, regional, continental and groupings on health personnel. This was also done through the Ministry of Foreign Affairs. Where need be, and in the context of ZUNDAF, were entered into these partnerships with the donor community. However, you find that donors only come in as partners to either provide relief aid or programme specific interventions in identified areas."

From this, a programme specific partnership on HIV/AIDS and TB was entered into with an international Non Governmental Organization in 2007. Given the severity of the HIV/AIDS situation, the international NGO implemented programmes to intervene in this community, whilst the government used resources generated from the National AIDS Trust fund to intervene in other parts of the country through the National AIDS Council. This organization complemented government effort towards the revitalization of the local human resources for health system in Epworth between 2009 and 2014, whilst enabling gradual transfer of responsibility and scaling down of operations during this period. This partnership, whose origins were traced back to 2007, was entered into at a very critical time characterised by lack of technical and human resource capacity which had made Municipal and Mission clinics dysfunctional. Initially, the organization deployed 20 Nurses whose salaries and allowances were donor funded to the largest and busiest Municipal clinic and community whilst the government deployed 8. In addition, the organization also deployed six Medical Doctors to help intervene on HIV/AIDS and TB. The organization also arranged to pay salaries and allowances for all healthcare workers for two years, after which it gradually transferred the responsibility to the government. By the end of 2014, the international organization had gradually scaled down its number of Nurses from 20 to 7, who remained to facilitate the

implementation and gradual scale down of its programme. During the same period, government increased the number of Nurses deployed at the Municipal clinic from 8 to 24, three of whom had been sent on study leave for post-basic training in Midwifery. Salaries for these 24 Nurses were paid by the government from the civil service payroll. In addition, the international NGO had facilitated the opening of a Municipal clinic specialising in Opportunistic Infections in 2007, at which 13 Registered General Nurses were deployed. This was meant to ease pressure on the Municipal Polyclinic and the Mission clinic for health services through increasing the number of healthcare providers. The NGO also provided technical assistance through on the job training on various aspects of health which resulted in the scaling up of HIV Voluntary Testing and Counselling, and anti retroviral treatment. In addition, it also facilitated the revival of the Village Healthcare Worker Programme/ Community Health Volunteers Initiative to help broaden the local healthcare worker resource base.

6.4.2 Result area two: Production, training and development

The objectives in this result area included the need to strengthen capacity for training health personnel in critical post-basic and postgraduate qualifications, and to support them towards this. In addition, other objectives also included the need to identify, develop and establish centres of specialization, the implementation of induction programmes, and the provision of training to managers on leadership and management skills.[4,5]

6.4.2.1 Capacity strengthening for training critical health personnel

This entailed building of capacity to train health personnel in critical and post-basic qualifications. It was established such training was undertaken at different institutions across the country. The most prominent were Parirenyatwa School of Nursing, Marondera Provincial Hospital, Harare Polytechnic College and the College of Health Sciences at the University of Zimbabwe. The first two institutions were deconcentrated institutions and as such the decision role on capacity strengthening was the responsibility of the Health Services Board and the Ministry of Health and Child Care. It was established that these benefited from government prioritisation as it intervened to improve the availability of human, material and financial resources to support their activities. For the later two however, it was established that the Ministry engaged them through the Ministry of Higher and Tertiary Education under which they fall. In this context, a Joint Health Planning Committee met regularly to discuss

priorities, responsibilities and to set training requirements and parameters. There were no training institutions in Epworth peri-urban community. Capacity strengthening for the training of critical healthcare workers was undertaken by training institutions across the country through the relevant Ministries under which they operated. In this regard, decision making authority on capacity strengthening for training critical human resources did not extend to the Epworth Local Board and other actors in this community. It seemed that the lack of technical and financial capacity accounted for this scenario.

6.4.2.2 Support for post-basic training

This involved decision making towards the provision of support to enable health personnel to pursue post-basic Diploma, Higher National Diploma, Degree and on the job training. The decision making authority to support health personnel was made by the Ministry of Health and Child Care, and the Ministry of Higher and Tertiary Education. It was established that this support was provided to health personnel at the two Municipal clinics and one Mission clinic. There were administrative norms and standards of the Ministry of Health which provided guidance on the support was provided to healthcare workers. Amongst the support interventions included facilitated enrolment, paid study leave, and tuition fee waiver for Diploma or Higher National Diploma courses which included Nursing and/ or a specialist course such as Midwifery offered at a government hospital training institution such as Parirenyatwa School of Nursing. In this scenario, it appeared as that the provision of support was guided by post-basic training priorities of the Ministry of Health and resource availability.

Support for post-basic training was provided by through the District Medical Office supported and advocated for increased production output of health workers with critical post basic and post graduate qualifications at the two Municipal clinics and one Mission clinic in two ways. Firstly, when a training opportunity for candidates was sent out from the Provincial Medical Office, either participants would be selected based on a defined criteria such as cadre, speciality, seniority or years in service. Apart from this, a roster would be used for rotation based selection, or consultations were made through the Local Board, which would engage the Community Health Officer on the matter. Final approval for decisions made at a lower level was made by the Provincial Medical Office for a healthcare worker to be enrolled for post basic and postgraduate qualifications. It was established that two

healthcare workers from one of the municipal clinics were away on study leave after having been enrolled at Parirenyatwa School of Nursing for a Midwifery Diploma. Two other healthcare workers from the mission clinic were also away on study leave after having been enrolled at Parirenyatwa School of Nursing for a Midwifery Diploma. On this, one medical respondent expressed appreciation for the support they received from the DMO's office to pursue post-basic and postgraduate qualification when they stated the following:

"Our DMO is very supportive towards our enrolment for post-basic and postgraduate qualifications. When a training opportunity arises from the PMO, the DMO is quick to communicate with us, or even visit to encourage us to apply. They also link us to other training schools throughout the country. Our DMO facilitates our application and enrolment process towards undertaking this training. Nomination of candidates for post-basic training, mainly in Midwifery, is based on seniority. This means that selection at each clinic is based on how long you would have worked there. One only needs to be patient enough to wait for their turn to come before getting their chance to go for training. As we speak, two of our colleagues are away on study leave. They have enrolled for a course in Midwifery at Parirenyatwa School of Nursing."

Other respondents however had different opinions on this as they were concerned about the lack of opportunity to pursue further training in areas of their choice. On this, one of them stated that:

"I am considering leaving the nursing profession to pursue a Degree in Environmental Health because the hierarchy is not flexible and the opportunity for selection. The District Medical Office selects people based on seniority and so it takes longer to receive an opportunity if you are junior and new. It seems that these older ladies feel threatened by our desire to pursue further education. In the end, I am forced to wait for 7; 8 or 9 years to receive an opportunity to go for training which will enable me to specialise in an area such as midwifery, against my interests. Besides, working here means that I am forced to specialise only on the services available in this district and nothing else. You are forced to take up what they offer and they ignore your own needs as an individual. No one listens to you here and there is no forum to discuss issues and lay out our grievances regarding career advancement. I want to do a Degree in Environmental Health. If they do not want me to offer

that opportunity then I will have to do it in a different capacity elsewhere and not as a nurse here."

To overcome this obstacle, it was established that individual health personnel could make applications for training in post basic and post graduate qualifications to learning institutions on their own. After securing a place, one would then apply for a study leave to the Ministry of Health through the District Medical Office which would then forward the submission to the Provincial Medical Office for approval. It was established that approval would depend on a review of the relevance of the prospective course to the service requirements. In addition, approval also seemed to depend on other factors such as the implications on the workload and the potential for disruption of service delivery. However, this option appeared difficult to pursue, particularly in fields removed from the immediate workplace requirements. Another major stumbling block was the unavailability of funding to help finance the studies. Support was next to non-existent as stated by one respondent as follows:

"I was offered a place to study for a Degree in Development Studies by one university. However, my wish is that the government provided financial assistance to facilitate my enrolment. The lack of finance must not be a stumbling block of concern so they should just provide support because in the end I will also provide services to the nation. I also require a paid study leave to further my studies because I cannot study and work and study at the same time given my workload at this facility. As you observed this morning, I had very long queues of patients to attend to. I hope this gives you an idea regarding the amount of work that I do daily. After that, they should also give me an option of getting a salary cut for a shorter bonding period and not just bonding only."

The option to pursue Degree Programmes was difficult for health personnel given the funding options at Universities in Zimbabwe and abroad. Compounding this was that other alternative sources of funding such as study loans had negative implications on the low salaries of health personnel. This was further compounded by prospects for further staff shortages and complains of a heavier workload experienced by others who would remain behind to fill the void left, a concern raised by one respondent who indicated the following:

"We are already seriously short staffed such that when one goes on study leave it becomes worse. It means that one would have to take up the workload left by whoever would have gone on training such that you end up covering a whole department meant for three health personnel on your own."

It seemed all these factors contributed towards the low numbers of health personnel who possessed post basic qualifications, or were enrolled for post basic training during the period of 2009 and 2014 as outlined in Table 9 below. For the local human resources for health system in Epworth, support and opportunities for health personnel at the private clinics in this community were also limited, few, far in between and in some cases non-existent as they depended on their employers. Whilst employees were allowed to pursue self initiated candidature for enrolment towards post basic and postgraduate qualifications, it seemed that their decision to take up candidature often had implications on their job security as the employers could not afford providing benefits such as paid study leave. As a result, it implied that one had to make a sacrificial choice of either losing their job to further their studies and possibly become unemployed thereafter or keep it without any further training. As a result of all these dynamics, the proportion of nurses who managed to enrol for post basic education and support to pursue them between 2009 and 2014 was only three out of a total of 59 nurses in the community. Of these three, two were employees at the Municipal clinic whilst one was employed by the Mission.

Table 9: Numbers of Nurses enrolled for and/or possessing post-basic qualifications

	Total number of Nurses	Nurses enrolled for post-basic training	Nurses with post-basic qualifications	Other cadres enrolled for/possessing post-basic training
Local Board/Mission Clinics	37	3	6	0
Private clinics	10	0	1	0

Fieldwork dataset

As a result, most nurses remained with the qualifications that they acquired before this period. It was also established that 5 had midwifery training, post basic Diploma qualifications which they acquired before 2009. Of these, only one of nurses was employed

by the private sector. Other cadres who included Nurse Aides, Environmental Health Officers, Laboratory Technicians and Pharmacy Technicians were neither enrolled for nor possessed post-basic qualifications. In a bid to counter limited opportunities for post-basic training, the District Medical Office facilitated attendance to regular in-house training workshops for health personnel at the two Municipal clinics and Mission clinic.

These in-house training workshops were attended mainly by medical personnel who included Registered General Nurses, Midwives, Primary Care Nurses and Environmental Health Officers. Non-medical personnel such as Nurse Aides were often left out for the simple reason that the training was meant for medical personnel. It appeared that all medical personnel had attended at least one training workshop on a particular medical subject. These trainings were also determined by funders. From the respondents, it was established that they attended workshops on subject areas which included Rapid HIV Testing, Malaria and TB Management, Sexual and Gender Based Violence, Screening for TB, Anti Retroviral Treatment and STIs, Cancer screening, and Male Circumcision. In addition, they also attended workshops which include Prevention of Mother to Child Transmission (PMTCT), Pediatric and Adult Opportunistic Infections (PAOI), Mentorship, IMAI-IMPAQ, Nutrition Management, Energy Planning, Adherence Counselling, Multidrug Resistance for TB, Health Promotion and Advocation, Water and Sanitation, Kaposi Sarcoma, and Monitoring and Evaluation of Health Services. The Nurses indicated satisfaction in these training workshops. They indicated that they instilled their confidence to work and also provided guidance on how to provide certain services, such as the initiation of HIV patients on ART, a skill and knowledge which they acquired during this period. On this, one respondent stated the following:

"The training workshops which we attended were good for our work because they gave us knowledge which instilled confidence in what we do. However, refresher training courses are necessary to enable us to keep up with developments on health issues and stay ahead because sometimes you find that, due to technology and the spread of internet onto cellphones, patients have more knowledge that you the service provider on a particular aspect of health and it is very embarrassing to be in that situation. In addition, refresher courses are necessary because health and medical practice are dynamic and ever changing."

Despite this however, Sisters in Charge at health facilities stated that there were training gaps amongst healthcare workers. Amongst these gaps included training on patient handling in a high pressure environment and difficult work situation. Further, it was also established that each Nurse did not attend all the training workshops despite working in an environment where such training is required. As such this often resulted in pressure on one individual who would have received training on a particular aspect. Health personnel indicated that they required training on all aspects of their work, in addition to refresher courses which were viewed as necessary to keep up with developments and stay ahead of patients. Apart from this, the majority of the Nurses indicated the need for training on Midwifery. On this, some indicated that they often got stranded when a pregnant woman in an emergency situation came to their facility for medical assistance. Others however indicated aspirations for further education in different areas such as Community Development, Public Relations, Motor-bike Training for community outreach and the Ebola Virus. State Certified Nurses raised their concern regarding exclusion from attending some workshops. As a result, they felt demoralised that their position was treated as irrelevant and addition to being incapacitated. Community Health Volunteers also indicated that they required further training in counselling and first-aid patient care to help them in their outreach work in the community. Human Resource for Health Managers (Sisters in Charge) indicated that they required training on Health Service and Facility Management. They indicated that this training was necessary to help them avoid making administrative errors as a result of experience based management.

Regardless of this, task, organizational and individual training needs, it was established that training impacted positively towards addressing the community's main health challenges which included Cholera, HIV/AIDS and TB. For instance, it was established that Cholera was completely eradicated during the period 2009 to 2014 as a result of the training on water and sanitation. Before 2009, it was established that HIV/AIDS and TB had been the main cause of motarlity in Epworth. It was also established that HIV/AIDS and TB interventions had become literally non-existent due to the unfavorable socio-economic situation which peaked in 2007 and 2008. Comparatively however, between 2008 and 2013, significant progress was made towards fighting this disease as outlined in Table 10 below.

Table 10: Comparing HIV/AIDS and TB facts and figures in between 2008 and 2013

	2008	**2013**
Number of HIV/AIDS tests done in clinics	1 964	8 712
Of those, number of positive results	491	2 407
Number of patients initiated on ART	370	1 762
Number of TB patients newly diagnosed and put on treatment	391	494
Number of MDRTB Patients taken into care	0	8

Fieldwork dataset

From the data in Table 11 above, it appears that the training and support provided resulted in more patients receiving testing for HIV/AIDS, being initiated on ART and being put on TB treatment in 2013. These figures are more favorable compared to 2008 when a lesser number of people received the same services. It was established from community members that before 2009, most locals were reluctant to seek or reveal their HIV status because of the fear of stigma. It appears that this view is supported by the lower number of 491 people that tested positive in 2008. This low number suggest that most people who suspected that they were HIV positive were reluctant to come forward to confirm their status or sought services in other areas to avoid the stigma associated with their HIV positive status. However, it was also established from community members that between 2009 and 2014, intervention by the Ministry of Health through the international NGO, and local board and mission clinics helped significantly reduce stigma and as a result, more people started coming forward to confrimn their status and seek treatment.

"before 2009, most people were reluctant reveal their HIV status or seek to know their status at clinics in this community because of the fear of stigma. HIV was viewed as a death sentence and once it was established that someone is, you would find that other community member would shame and shun that person to point of even refusing to shake hands with them. As a result, most people died in silence. There were others who also died as a result of failure to access treatment as there was also no medicine at the local clinics. However, starting from 2009, there was a massive education and treatment campaign by the international NGO that penetrated into household. This helped to significantly reduce stigma as most people became more knowledgeable about HIV, and it not being a death sentence. As

a result, most people became aware that HIV is just like any other disease and that there are treatment options available through the municipal clinics free of charge. From this, people are no longer ashamed of having HIV and they are coming forward to receive antiretroviral treatment. As a result, lesser and lesser people are dying. Ofcourse there are a few cases of stigma but the fewer perpetrators are viewed as being shameful and less knowledgeable than anyone else."

It appears that this view accounted for the increase in the number of HIV positive results that contributed to the higher figure of 2 407 in 2013. This increase is a positive outcome of the scalling up of HIV/AIDS interventions by the Ministry of Health and Child Care and the international NGO, mainly through the municipal and mission clinics in this peri-urban community.

However, opportunities for critical post-basic and postgraduate training were literally non-existent for healthcare workers in the local private sector. Whilst employees were allowed to pursue self initiated candidature for enrolment towards post-basic and postgraduate qualifications, it seemed that their decision to take up candidature would come at the expense of keeping their job. It implied that one had to make a sacrificial choice between losing their job to further their studies and possibly become unemployed after or keep it without any further training. There were no options for financial support from their employers or options for a study leave. The desire for further education seemed a distant endeavour amongst healthcare workers in this category, the majority of whom were new and possessing their basic qualifications. Above all the financial cost for this endeavour was beyond their means as their salaries were much lower than their counterparts in the public sector. The respondents in this category indicated training needs prominent of which was Midwifery. One healthcare worker at a 24 hour private clinic stated that sometimes they have patients coming during midnight in labour and it becomes difficult to help without knowledge. Another indicated the need for training on HIV/AIDS Adherence counselling indicating the need to intervene because patients on ART were found not to be drug compliant. Others however lacked training on health alltogether and were unable to handle patients in the absence of a qualified Nurse or Medical Doctor. In there were a few healthcare workers, employed in the capacity of Nurse Aid, who did not have any health qualifications. Amongst these was one who indicated that they were in the process of supplementing their Ordinary Level Mathematics

subject with the hope of writing exams at the end of the year. In the context of a private clinic, it was established that these would just be employed to give a helping hand to the qualified staff and also to be at the facility when the Doctor is not around. Consequently, The given that the P value is less than 0.05, the null hypothesis is rejected because the average number of staff to have post-basic training is not equal to 47. The null hypothesis in this case is rejected because only 7 out of the 47 Nurses in Epworth have either received or were receiving pot-basic training in specialistic areas such as Midwifery. It is worth noting that 3 of these 7 were enrolled for training on Midwifery at the time of the study. Whilst the objective of the Human Resource for Health Policy of 2009 and 2014 was to ensure that all healthcare personnel access post basic training, these numbers reflect the progress made on that endeavor.

6.4.2.3 Decision making towards establishing centres of specialization

It was established that centres of specialization were meant to provide on the job training and development of healthcare workers on a particular medical area to the effect that healthcare workers will be rotated between these training centres within a district or province. The technical and financial aspects involved meant that decision making authority on this was undertaken by the principal through the Provincial Medical Office. However, it was established that between 2009 and 2014, the implementation of this decision was undermined by financial constraints. This stumbling block undermined the establishment of centres of establishment in the province. As a result, the province relied on output from training institutions throughout the country such as Parirenyatwa School of Nursing and the College of Health Sciences at the University of Zimbabwe. Efforts were still being made to lobby for funding and technical assistance from stakeholders to see this matter through in the post 2014 period. The Local Board itself did not have any funding or technical capacity to intervene in this area.

6.4.2.4 Induction and exchange programmes

These programmes were aimed at facilitating the exchange of experiencies and facilitating the introduction of healthcare workers to the work structures and systems in their district and province. The implementation of induction and exchange programmes was based on administrative norms and standards of the Ministry of Health. Decision making on this was centralised and undertaken at the provincial level. However, it was established that this policy

idea had fallen away due to lack of funding. To counter the possible effects of this on healthcare worker induction, the Provincial Medical Office innovated by developing an induction manual, just as a stop gap measure for use in the event of emergencies such as disease outbreak. On exchange programmes, interprovincial peer visits between hospitals were said to be encouraged even though the reality of this manifesting in Epworth seemed distant due to lack of funding and personnel. It appeared that priority was directed towards containing health personnel shortages in the community.

6.4.3 Result area three: Deployment, retention and performance management

The policy outcomes sought in this result area included the deployment, retention and management of ad adequate number of equitably distributed and qualified healthcare workers.

6.4.3.1 The gains of collaborative decision effort in healthcare worker deployment

The socio-economic challenges of pre-2009, and financial incapacity on the part of the local board and mission, meant that ministerial intervention was required towards the deployment of healthcare workers between 2009 and 2014. From this, there was collaboration with the Ministry of Health and Child Care, which intervened through its District and Provincial Medical Offices. As a result, the total number of nursing staff[vii] (Registered General Nurses, Midwives, State Certified Nurses, Primary Care Nurses) increased from 17 in 2007 to 56 in 2014 as outlined in Table 11.

Table 11: Increase in the number of human resources for health

	2007	**2014**
Nursing staff	17	56
Other non-medical cadres	7	45
Total	**24**	**101**

Source: Fieldwork dataset

Of these 56 Nurses in Epworth, it is important to note that 45 were were on the civil service payroll whilst the rest were employed by the local private sector. In addition, the number of

[vii] Nursing staff are medical cadres qualified to provide direct patient care. They included Registered General Nurses, Midwives, State Certified Nurses, Primary Care Nurses.

other cadres[viii] (Nurse Aides, Environmental Health Officers, Primary Counsellors, Pharmacy Technicians, Dispensary Assistants, Pharmacy Technicians, Ambulance Drivers, Laboratory Scientists) increased from 7 in 2007 to 45 in 2014. 32 of these cadres were on the government payroll. Perhaps it is also worth noting that the increase in the number of health cadres was greater than the population increase between 2002 and 2012. For instance, at the Mission clinic, the number of healthcare workers increased from only 4 Nurses and 3 Nurse Aides in 2007 to 8 Nurses, 4 Nurse Aids, 2 Primary Counsellors and 1 Environmental Health Officer in 2014. In addition, a pool of about 30 Community Health Volunteers deployed in the capacity of either Village Health Worker/Community Health Volunteer or Peer Educators was also an addition. However, despite this improvement, the number of healthcare workers fell way short of requirements. Perhaps one of the interventions to bring up numbers was through the enhancement of the contribution by the local private health sector towards easing these shortages in Epworth. It was established that between 2009 and 2014, the total number of Private clinics[ix] in this peri-urban community grew from three to seven. Even though these clinics were much smaller in size and operational functions, they presented a complementary and alternative health care service delivery channel in this community. Local private health sector participation was facilitated through the issuing of operating licences by the Epworth Local Board following approval of each proposal by the Ministry of Health and Child Care. As a result, the local private health sector contributed 11 out of the 56 Nurses, and 6 out of the 27 Nurse Aides as outlines in Table 12.

[viii] other cadres are support staff who provided indirect patient care. They included Nurse Aides, Environmental Health Officers, Primary Counsellors, Pharmacy Technicians, Dispensary Assistants, Pharmacy Technicians, Ambulance Drivers, Laboratory Scientists.

[ix] Private clinics were local privately owned and operated clinics which provided health care on a fee for service basis. They were owned by Physicians (Medical Doctors) who provided services at fixed times of the day (late afternoons and early evenings). However, these clinics opened for most parts of the day (some even for 24 hours) and provided services through one or two Nursing staff and/or Nurse aids. They were much smaller than Municipal clinics and the Mission clinic.

Table 12: Sector contributions towards Human Resources for Health

	Public sector	**Private sector**
Nurses	45	11
Nurse aides	21	6
Totals	**76**	**17**

Source: Fieldwork dataset

In addition, the sector also contributed 7 General Medical Practitioners who operated these clinics. This provided an additional option for higher level health care in this local context, considering that there were no General Medical Practitioners at the two Municipal clinics and one Mission clinic in this peri-urban area. Whilst one may argue that the international NGO deployed 6 Medical Doctors at one of the Municipal clinics, it is worth noting that these were programme specific staff who specialised only on attending to HIV/AIDS and TB patients at this clinic and the community. It was established that whilst they were flexible to attend to a few emergency cases outside their scope when the need arose. However, their attendance did not extend much to other cases in a manner similar to that of the General Medical Practitioners at the Private clinics. It is however worth noting that the services by General Medical Practitioners at the Private clinics required a consultation fee which made their services out of reach to some members of the community. Compounding this was that, they provided services only during certain fixed times of the day such as during afternoons to early evenings, even though the majority of the clinics would be open the whole day. This limited the extent to which locals could access a General Medical Practitioner in the community. There is no denying the potential for significant contribution by the local private sector to help ease pressure somehow on Municipal clinics and the Mission clinic within regulated cost parameters and possibly assistance from philanthropy.

Nevertheless, collaborative effort between the Principal and Agent towards the deployment of healthcare personnel resulted in improved availability of human resources compared to the situation before 2009. As a result, Epworth had a physician to patient ration of 0,08: 1000, as outlined in Table 13 below. This ratio included the 7 General Medical Practitioners who operated private clinics in the community and 6 Programme Specific Medical Doctors from the international NGO.

Table 13: The Physician and Nurse to Patient Ratios

Cadre	Number	Average population size for Epworth	Epworth (2014)
Doctors: (7 General Medical Practitioners and 6 Programme Specific Medical Doctors)	13	161 840	0,08: 1000 (Physician to Patient Ratio)
Nurses: (Registered General Nurses; State Certified Midwives; Primary Care Nurses).	56	161 840	0,35: 1000 (Nurse to Patient Ratio)

Source: Fieldwork dataset

However, despite these improvements, the shortage of Nurses persisted in this community by the end of 2014. These shortages manifested by way of a heavy workload of healthcare workers at the two Municipal clinics and one Mission clinic. It was observed that these clinics congested with patients for most parts of each day and provided services to a whole lot more patients in this community compared to the private clinics. Of these three, the oldest Municipal clinic at Domboramwari local business and administrative area was the busiest as it provided a wider rage of services comparatively, and had an inpatient maternity ward which provided services for 24 hours, and an outpatients section which provided services during the day from 0730hrs to 1630hrs. It was also more centrally located along the main highway and appeared more easier and prefarable to access by most locals than any other clinic. As a result, it was established that a Nurse at this Municipal clinic attended to an average of 116 patients each day during this period, as outlined in Table 14.

Table 14: Mean number of patients attended to by a Nurse per day by facility type

Facility type	Average number of patients per day per nurse
Municipal Polyclinic	116
Municipal OI clinic	68
Mission clinic	93
Private clinic	11

Source: Fieldwork dataset

To cope with these numbers, the operating arrangement was that Peer Educators would pull files for patients as soon as they arrive. Nurse Aides would then check for vital signs such as

blood pressure and temperature before dispatching patients to relevant departments for medical attention by Nurses before being discharged through the dispensary department. In addition, there was a flexible work arrangement in which Nurses from the less busier departments would go to provide assistance in the more busier departments as soon as queues in those departments clear up. It was observed at this clinic that for most of the days, services in the outpatients section would continue to be provided even beyond working hours until everyone had been received medical attention.

In comparison, a Nurse at the Municipal OI clinic attended to an average of 68 patients. This clinic was relatively new because it had openned in 2011 and operated between 0730hrs and 1630hrs. However, it was not centrally located making it lesser accessible by patients compared to the Mission and Polyclinic. A Nurse at the Mission clinic attended to an average of 93 patients. The Mission clinic was the second busiest clinic because it was located in the most populated, oldest and most easily accessible part of the community comparatively. All the Nurses at the two Municipal clinics and one Mission clinic complained of a heavy workload to the effect that a few at the Polyclinic revealed that they were taking anti depressants to cope with the stress and burnout. This also seemed to affect the quality of service delivery at these facilities. Community members expressed their concerns over healthcare service delivery which they said improved significantly immediately after 2009 but started deteriorating after 2013 following the withdrawal of the international NGO on most aspects of service delivery.

"Service delivery improved significantly when the NGO came to help in the provision of healthcare at Municipal clinics in this community in 2009. There were improvements in the number of healthcare workers and the quality of services that they provided. These healthcare workers would go around the clinic seeking out unattended patients and providing prompt assistance. However, since 2013, things appear to have changed as the healthcare workers that are now there at the clinics are less concerned about patients. You find out that they do not seek out patients anymore and they are much slower in providing assistance. One has to wait for them as they walk slowly chatting from their tea and lunch breaks. In addition, you are made to sit in the queue in some departments at it takes longer for someone come to attend to you especially in the Dispensary. Compounding this is that some of the Nurses are not as friendly as was the situation before. We acknowledge the improvements which

occurred but are concerned that declining standards might eventually send us back into the crisis of 2007-08 when most people in this community died as a result of the failure to find treatment at the clinics"

These concerns relate to changes in service delivery that occurred from 2013 when the international NGO gradually started handing over operations to the Ministry of Health and Local Board. To help ease the burden on facility-based healthcare workers, there was the revival of the Community Health Volunteers Initiative.

The Community Health Volunteers Initiative in Epworth entailed the mobilization and recruitment of the community members. These volunteers were recruited and deployed into two categories namely the Community Health Workers/Village Health Workers and Peer Educators. The aim was to have them engage in beneficiary participation in non-medical roles, towards complementing the medical staff at local public clinics. These local institutions included two municipal clinics and one mission clinic. The first category, Community Health Workers, consisted of volunteers recruited by the international NGO which operated in the community. This organization provided training to these volunteers before deploying them into the seven wards of Epworth. In addition, the Ministry of Health and Child Care revitalised the Village Health Workers Programme. The manner into which locals were recruited into this programme was different from that of Community Health Workers in that the Village Health Workers did not just volunteer for this role. Rather the process involved volunteering, followed by selection community members from within their wards before recommendation for recruitment by the Ministry. It was however established that some of the Village Health Workers had also been recruited and trained earlier on under the Community Health Worker Initiative by the international NGO only to be selected again and trained by the Ministry of Health. Regardless of how they were recruited, the Village Health Workers and Community Health Workers where one team which played a similar role.

The role of these ward based Community Health Volunteers was to assist in outreach health interventions which included health communication, identification of unregistered pregnancies, basic home based care, patient follow-ups, and monitoring and reporting the local health situation. The arrangement was such that the volunteers were assigned to a local public clinic from where they operated. In this context, they would converge at the clinic

where they were attached on Mondays, Wednesdays and Fridays to provide feedback, report, caucus and deliberate and obtain assignments either directly from the Sister in Charge and/or through a Community Liaison Officer at the clinic. From this, the volunteers would engage in outreach activities on Tuesdays, Thursdays, and Weekends. It appeared that this intervention impacted positively as it this category of Community Health Workers helped in reaching out to the community, which eased the burden on facility based healthcare workers and improved the local health situation. However, there were challenges experienced by this category of healthcare workers which undermined the extent to which they could serve their community, and effectively mitigate the healthcare worker shortages in this peri-urban community. Prominent amongst these challenges included staff shortages, the lack of equipment, and lack of a basic allowance. From the Focus Group Discussions conducted, the Community Health Workers/Village Health Workers raised their concerns as follows:

"we are short staffed which undermines our ability to reach out into more parts of the community. Attrition and relocation to other jobs by our colleagues mean that there are on average two or three of us working in a ward. The initial standard set in consideration of our community size was five people per ward. As a result, this makes it difficult for us to reach out into a ward of well over 1000 households in the community as we are overwhelmed by work. We are also not happy with unfulfilled promises which include bicycles, first aid kit, the need to recruit more CHWs to bring the numbers back to 5 per ward, and monthly allowances which we have not been paid by the Ministry of Health for 11 months now."

Peer Educators were the second category of Community Health Volunteers in Epworth between 2009 and 2014. This group of volunteers was made up of HIV positive members of the community who volunteered for recruitment by the international Non Governmental Organization. They were trained by the international organization on how to provide non medical assistance to support service provision at these clinics. Unlike the Community Health Workers/Village Health Workers, Peer educators were deployed at public clinics to assist in the non-medical aspects of service provision such filling, basic counselling, and cleaning of the premises. However, whilst their deployment helped ease the workload particularly for medical personnel, who themselves were short-staffed, the unavailability of protective clothing and uniforms was raised as a concern which undermined their morale. From the Focus Group Discussion with Peer Educators, concerns were raised as follows:

"There is need for us to be provided with protective clothing to protect us from contracting diseases whilst working at the clinic. In addition, providing us with uniforms will make us appear equal in the eyes of the patients because some of us are very poor to the point that our clothes expose our poverty which is discomforting when working. At least uniforms will help conceal our poverty and make us more accepted and treated with respected by patients. In addition, the unavailability of uniforms makes it easier for us to be recognised as being HIV positive which exposes us to stigma. As a result, some patients call us names in such a way which is dehumanising and you do not feel good volunteering to provide your services each time you are ill-treated like that. We are also human and we deserve to be treated with dignity and respect like everyone else."

The concerns raised are policy matters which warrant attention beyond 2015 if these healthcare worker interventions are to contribute more effectively towards the attainment of the 2030 Sustainable Development Agenda (SDA). This is particularly true for policy effort towards Sustainable Development Goal number 3, aimed at ensuring healthy lives and the promotion of well-being for all at all age group categories, and Goal number 11, which is meant to make cities and human settlements inclusive, safe, resilient and sustainable.[14] Nevertheless, community members indicated that the deployment of more Nurses, Nurse Aids and CHWs had helped improve service delivery compared to the situation before 2009.

Community members stated that before 2009, a whole lot more people died at more regular intervals as a result of lack of treatment at the clinics, shortage of nurses, fear of stigma associated with seeking HIV/AIDS treatment and the lack of HIV treatment in the community. However, it was established from them that clinical services and outcomes had improved. More locals were now able to access ART and chances of delivering an HIV negative baby improved significantly. In addition, health promotion and awareness had been expanded into the community mainly through CHWs/VHWs and the international NGO which had resulted in a significant reduction of stigma. However they complained of a poor service at the Pharmacy Departments. On this, they indicated that there was a lack of medicine more often than not for patients not on ART. This led some into making allegations that medicine was being looted and being sold to private clinics for profit. They also complained of a poor patients filing system which they said often resulted in one being

delayed in receiving treatment as a result of the failure to locate files. They indicated that there was a need to use educated people and to increase human resources in the filing department. Some also complained of a change in the attitude of nursing staff towards them since 2013. They indicated that some of the nursing and pharmacy staff had become slower in attending to them or dispense medicine. In addition, locals also stated that the staff had become less caring to the effect that they often waited in queues much longer whilst waiting for them to either come from tea and lunch breaks or attend to the department in which they would have been asked to go to. These locals indicated that the situation before 2013 was a bit different in that staff from the international NGO moved around more often identifying departments with longer queues for prompt attention. It was however observed that no patients were turned away as effort was made to attend to clear all patients.

6.4.3.2 Decision making outcomes towards healthcare worker retention

This was a critical result area in human resource for health reform effort in this community. Decision making effort was aimed at reducing brain drain of the healthcare workers produced and deployed at local health facilities. The Ministry of Health and Child Care outlined the attraction and retention strategies in the Human Resource for Health Strategic Plan of 2010 to 2014 of the 2009 Human Resources for Health Policy. It was established that amongst the strategies proposed included the provision of adequate accommodation for staff, provision of loans for housing and transport, competitive salaries pegged at regional scales, housing allowance for staff, adequate protective clothing for staff, appropriate remuneration for additional responsibilities, guidelines for HIV prevention, tax exemptions and allowances. However, a lack of financial capacity by the local board and mission meant that collaboration with the Ministry of Health towards the implementation of a package of financial and non-financial healthcare worker retention strategies in Epworth was initiated. To this end, the Ministry of Health and Child Care arranged the payment of salaries for healthcare workers at the two Municipal clinics and one Mission clinic starting in 2009 because the Epworth Local Board lacked capacity in this area due to its narrow revenue base. To start with, remuneration packages were denominated in the United States Dollar in 2009 for reasons decsribed below. This had the effect of bringing about financial stability and certainty to healthcare workers as stated by one respondent:

"The Zimbabwe dollar had become uncertain due to high inflation. It was such that you would get paid one day but not afford transport to come to work the next day. It was a very difficult period. However, after 2009, things got better for us as we started receiving our salaries denominated in the US Dollar. Since then, things have stabilised and you can now budget even though the money is not enough to meet requirements."

In this context, the salary levels were determined by the Ministry of Health and Child Care through the National Budgetary allocation from the Ministry of Finance and Economic Development. Decision making on this was not decentralised to the Local Board between 2009 and 2014. In addition to this, arrangements were made to prioritise the payment of salaries without any delays each month. However, despite the fact that their salaries were comparatively higher than those for healthcare workers at the seven private clinics located in the community, and there no being delays in their payment each month, most healthcare workers stated that their salaries were not adequate enough to make ends meet. One respondent eaplained this as follows:

"My monthly salary of US$500 is not enough to meet my expenses mainly transport, food, clothing and school fees for my children. The mission used to pay school fees for us but now it has since stopped and things are getting harder for us. Maybe if the salary was increased it would be better because you find that our colleagues working in the private sector in other places earn US $1000 per month, whilst those at the international NGO working in this community earn US$1500, which is more than double our monthly earning."

Some were not happy that the transition of 2013 from having their salaries paid by the international NGO to the government had resulted in a reduction in their salary.

"I used to earn $762 but it was reduced to $662 including top up allowance when the international NGO stopped paying us."

Another respondent was concerned about the salary grading system stating that it was not based on qualifications and did not consider factors such as work environment and work load.

"the grading system must improve because currently a nurse earns $500 per month whilst a guard earns $400 per month. This is not fair at all considering the differences in qualifications. In addition, you find that a degreed nurse and a non degreed nurse both fall in the same grade which makes it seem as though there is no benefit in furthering your studies. There should be a beneficial solution regarding education. Salary grades must be based on the level of education, and should also be based on the state of the working environment, workload and the number of patients one attends to each day."

Some respondents in this category indicated that their salary did not match their expectations because of the risk of contracting diseases whilst providing treatment to patients. Some indicated that this left them in a state of stress and depression. On this, one respondent indicated the following:

"I work in the TB Department where I have a higher risk of contracting the disease but there is no compensation. If you contract MDRTB, there is no guarantee that you will keep your job afterwards because they only give you 90 days of sick leave yet it takes between 6 to 7 months, or even 2 years of treatment. During this period you will be infectious to patients but yet you are expected to be on duty else you will be fired if your 90 days of sick leave lapses. There is no policy to cover health cadres from TB in the event that you contract it on duty. Compounding this is that it is highly likely that I will contract it in the TB department that I work in. It makes me very scared because in the event that I contract the disease, there is no security for me from the government yet I am sacrificing myself on the frontline to serve the nation."

A few respondents revealed having secondary employment at private clinics in other communities around Harare where they work part time after hours, during weekends and during their off days to supplement their monthly incomes. Some also revealed taking anti depressants to cope with stress. Others revealed plans to apply for nursing jobs in other neighbouring and overseas countries. A few indicated plans to enrol for university degree programmes to change their profession all together. Others revealed that they were taking anti depressants to cope with the stress associated with a combination of inadequate salary, heavy workload, burn-out and higher risk of contracting diseases. Others revealed plans to apply for nursing jobs in other neighbouring and overseas countries. A few indicated plans to enrol for

university degree programmes towards changing their profession all together. To help address this situation, it was established that the Local Board and the Mission complemented central government effort through the payment of a monthly top-up allowance to healthcare workers at the two Municipal clinics and Mission clinic. It was established that the top-up allowance of US$120 was paid during the middle of each month and was separated from salaries. In addition, it was also established that there was a donor allowance paid to healthcare workers at these facilities. The payment of this allowance was however considered inconsistent and insignificant as the amount paid was said to be very low, varying between USD$20 and $50 each month. Respondents revealed that the top-up allowance helped supplement their salaries. The fact that the allowance was paid in the middle of each month also helped them to meet transport costs as their income would have run out at that time. On this, one participant responded to this strategy by stating the following:

"The top-up allowance that we received from the Local Board helped supplement our income. This is because you find that we receive this payment during the middle of the month, time by which our salaries would have run out. As a result, we are able to meet the transport cost which enables me to continue coming to work whilst waiting for my next salary to come. However, it should be increased to about $300 per month so that I am able to sustain my family for the whole month. We also get a donor allowance but the payment of this money is not consistent and its amount is much lower than what we are getting from the Local Board. Sometimes it is just $20 whilst at other times it is $50. At least it helps whenever it comes because the donor pays it when we do not expect it."

It was however established that some of the healthcare workers at these facilities did not receive the top-up allowance. At the Mission clinic for instance, top-up allowances were paid to healthcare workers who worked at this clinic before 2009. The decision to pay these top-up allowances was made by the Mission. These included only 4 Nurses and 3 Nurse Aides. The remaining 4 Nurses, 1 Nurse Aide, 2 Primary Counsellors and 1 Environmental Health Officer did not receive the top-up allowances. At the Municipal polyclinic, it was also established that healthcare workers who were absorbed onto the civil service payroll by the government from the international NGO in 2013 did not receive the top-up allowance too. The decision to pay top up allowances for this category of health workers was made by the Local Board. However, this shortcoming by the Mission and Local Board created a strong

sense of exclusion and division amongst this category of healthcare workers as expressed by one nurse who stated the following:

"Not all of us receive those top-up allowances. Those of us who started working here in 2013 are not receiving those top up allowances. For me this it is demoralising and I cannot get it out of my mind when working because we do the same job and serve the same patients but are treated differently. Someone might even be at school doing Midwifery receiving the top up allowance whilst you are on duty each day but getting nothing. This is not fair. It hurts and makes you feel unwanted, unappreciated and less special than those that are getting. The other thing is that I am a Registered General Nurse but then you find that a Nurse Aid is receiving the top-up allowance whilst you do not. How do they call some of us to go and receive those top-up allowances from the same consultation room that we will be working. We have engaged them on the matter but they seem reluctant to respond. I am not happy about this at all"

Apart from these financial incentives, there were also non-financial retention strategies. These included free residential stands, free accommodation, protective clothing and sundries. The Local Board also provided free residential stands as a benefit for long service by their health staff. It was also established that those that had worked at these two facilities before and after 2009 had already received this benefit.

"I was allocated a residential stand as part of a long service award. I had managed to complete a period of 5 years of service here and the Local Board rewarded me. I did not have to pay a cent for it. I am happy about this."

Some healthcare workers at the Mission clinic were also provided free accommodation by the mission. The mission was owned by the church. In addition, healthcare workers at the Municipal polyclinic expressed appreciation in effort by the Local Board to support their daily work in service delivery through the responsive provision of sundries. One respondent indicated the following:

"The Local Board supports our work here at this clinic. They are very responsive towards our needs. If we request sundry such as vim, soap and methylated spirit, they deliver on time

which means that there will be no strain for us in delivering services. Whenever we prepare our paperwork on time, they also respond timely."

However, there was a lack of happiness owing to the withdrawal of certain benefits that they used to receive before 2013. Amongst these included uniforms, a jersey, soap for washing, school fees for their children and free lunch at the workplace. The majority indicated that their transport allowance did not compare with the actual cost of transport which was said to be double the requirement as they do not live in the Epworth. On this, some suggested an increament of the transport allowance whilst others proposed that a staff bus should be provided to ferry staff members to and from a central pickup point in Harare's Central Business District each morning and evenings. Others proposed that the Local Board must construct houses for Nurses in the community, and allocate them residential stands on the basis of other criteria which are not seniority. Others proposed car loans, study loans and just loans to meet their financial needs when the situation arises. These matters were discussed at a local level between the mission, local board and international NGO. There were no consequenses if the NGO provided incentives outside of the government rules. However, their operations appeared constrained by limited resources too.

On the other hand, private clinics enjoyed autonomy in the implementation of retention strategies amongst their healthcare employees. Amongst the strategies used include: employment based on kinship ties; airtime allowance; soft loans; free medical treatment for family members; free transport to the workplace; free meals at work; less workload due to fewer patients; medical equipment and flexible working hours. Despite these interventions, some of the healthcare workers were not satisfied with low salaries and delays in salary payment. It was established that healthcare workers at some facilities were only paid an agreed fee per patient (capitation). The salaries were comparatively much lower in this sector than at the two municipal clinics and one mission clinic. There were also limited opportunities for training and development as there were no opportunities for study leave or to attend training workshops, opportunities which healthcare workers at the municipal and mission clinics enjoyed. It appeared that most of the healthcare workers in this category were in it either as secondary employment, just to gain some working experience or because it was the only job available to them at that time. A summative overview of the benefits received by healthcare workers from their employers is outlined in Table 15. To this end, 60 healthcare

workers received housing a housing allowance from their employer. Of these, 36 were medical personnel whilst 24 were non-medical personnel.

Table 15: Benefits received from all employers in the public and private sectors

Benefits	**All (N=87)**	**Medical staff N = 47**	**Non-Medical staff N = 40**
Housing allowance	60	36	24
Protective clothing	42	17	25
Donor allowance	39	29	10
Top-up allowance	35	24	11
None	13	2	11
Food at work	6	3	3
Transport to workplace	16	0	16
Stand	3	1	2
Transport allowance	3	2	1
Other	3	0	3
School fees loan	3	0	3
Airtime	2	2	0
Free accommodation	1	1	0
Building loan	1	0	1
Study loan	1	0	1
Medical aid	1	0	1

In contrast however, only 1 of the respondents indicated that they had received free accommodation, a building loan, study loan or medical aid. 13 healthcare workers, 2 of whom were medical personnel in the local private sector indicated that they had received no other benefit at all. However, despite these interventions, it appears these impacted less successfully towards healthcare worker retention. Most healthcare workers in this community indicated lack of satisfaction with their working conditions and considerations to leave their jobs. Some indicated plans to leave their profession. It however appears that limited

opportunities elsewhere are the only factor that might stop healthcare workers from leaving their profession.

6.4.3.3 Performance management decisions

Performance management was undertaken by the Provincial Medical Office through the District Medical Office. It was also underatken by the Sisters in Charge at the clinics in collaboration with the Community Health Officer. The Ministry of Health and Child Care proposed the Results Based Performance Management System to help manage the performance of healthcare workers in line with its administrative norms and standards. However inquiry at the Provincial Medical Office revealed that this system was yet to be taken up in the province in which Epworth falls due to lack of technical capacity. As a result, it was established that the Provincial Medical Office, District Medical Office and Community Health Office continued to use the Performance Appraisal Form developed by the Public Service Commission (PSC) before 2009. It was however established that performance appraisal of healthcare workers in Epworth was not undertaken during the period between 2009 and 2014 after the deliberations between the Principal and Agent actors led to the realisation that the Performance Appraisal Form did not reflect on the context of work. In practice managing performance was overshadowed by staff shortages, and the visibly overwhelming workload which had an overstretching effect for staff in a high pressure environment. For healthcare workers at private clinics, performance management took place through mutual discussion and advice between the facility manager/ owner and the healthcare worker.

6.4.4 Result area four: Health labour relations

This result area focused on the employer-employee rights framework, towards upholding of the rights of health care employers and employees on all aspects of employment. The Ministry of Health and Child Care through the Health Services Board intended to promote health employer-employee relationships for a well-defined system of rights, obligations and sanctions enforceable at law in order to promote worker morale, and production within the spirit of mutual respect. To this end, the aim was to make sure that healthcare workers are conversant and comply with the laws, policies, regulations and rules governing their employment conduct including compliance with professional ethics, oaths, pledges and other obligations. Apart from this, the aim was to ensure that the workforce was not deprived of its

rights and privileges. The rights of the employer and employees were provided for in legislation which include Section 29 of the Constitution of Zimbabwe, and Statutory Instrument 88B of 2005 from the Health Service Act (Chapter 15:16 No. 28/2004).[26,29] Through this legislation, the Health Services Board in consultation with the Minister of Health and Child Care inquired into and dealt with complaints made by members of the health service. In addition, there was also the Labour Act (Chapter 28:01) governed relations between employers and employees in this regard.[31] Further, the Public Health Act (Chapter 15:09) which made provisions for the establishment of the Health Ministry, District Health Management Committees, Local Health Authorities, Health Committees and duties thereof.[27] Apart from this is the Medical Services Act (Chapter 15:13) governed the establishment of health facilities at all levels of society.[28] There was also the Health Professions Act (Chapter 27:19) made provisions for the establishment of the Health Professions Authority of Zimbabwe and councils for practitioners.[30] However, it appeared that the centralized nature of the framework, and the difficult socio-economic context that prevailed meant that healthcare workers were aparthetic towards health labour relations.

6.4.5 Results area five: Health and safety welfare

There were two result areas in this policy area namely health, and safety. With regards to health welfare, decision making was concerned about medical aid cover (medical insurance) for healthcare workers and their families. It was established that healthcare workers at the clinics were free join a medical aid scheme of their choice on own, and at their own cost as there was no medical aid cover arrangement for them. As a result, this made healthcare workers reluctant to join medical aid schemes because of the effect that it would have on their low salaries. On this regard, some respondents proposed that there should be a free medical aid scheme or special subsidised medical aid scheme for healthcare workers.

"I propose that the government should provide either a free or subsidised medical aid scheme to health workers and their families so that they are able to access healthcare elsewhere at a discounted rate when the situation arises."

Private clinics in the community innovated by offering free medical treatment for their healthcare workers and their families. On the other hand, healthcare workers at the municipal clinics and mission clinic could access free medical care for themselves and their families

like any other member of the community if it was within their financial means. For healthcare workers at the two Municipal clinics and one Mission clinic, the researcher observed that the need for a medical aid scheme was a silent requirement whose relevance would inevitably reveal itself in the event that one contracts MDRTB which would require complicated treatment procedures that might not be readily available in the community. In addition, it was established that the maximum sick period for healthcare workers is shorter than the amount of time it would take to receive full treatment. This concern was raised by one respondent at one of the municipal clinics who stated the following:

"There should be special medical aid arrangements for us who work in the TB Department to cater for my treatment in the event that I contract MDRTB. This MDRTB two years to treat, which is longer than the 90 days of sick leave that they give us. It therefore means that if I contract it I will risk either losing my job or be forced to come to work sick where the risk of infecting others is higher. They should do something about that."

Apart from health welfare, healthcare worker safety and protection was also a decision area. There were clinical procedures and standards set by the Ministry of Health and Child Care, in line with the World Health Organization Requirements. These outlined protocol to be followed to protect healthcare workers from accidential infection whilst on duty. The most prominent of these were the Prophylaxis Guidelines which were helping protect healthcare workers from accidental contraction of HIV/AIDS whilst performing their duties. They helped instil a sense of protection amongst healthcare workers. However, it appeared that the lack of training amongst non-medical personnel, particularly Nurse Aides who worked in medical service areas, but yet are excluded from in-house training and development on this, undermined enforcement. For instance, as a result of lack of knowledge, the researcher came across one Nurse Aide at one public clinic did not administer Prophylaxis on herself within the stipulated time period of 72 hours after accidentally exposing herself to HIV infection. The Nurse Aide narrated her experience in the following manner:

"One day whilst working on a night shift there around September-October 2012 there was no electricity at our facility on one Friday night. We also did not have a generator that night. A patient who was not booked came into our facility in labour and the baby immediately started coming out whilst they were in the corridor before they could be taken into a ward. It was an

emergency situation which forced us to assist the patient in having the delivery take place there in the corridor before they could be taken into a maternal ward. In the midst of the confusion that was unfolding, in separating the mother from the child and in the darkness, everything that had been used during the delivery was put into the same receiver. Immediately afterwards, as I separated the utensils from other material to be discarded, I did not see that the surgical blade that had been used to cut the umbilical cord had been left in the receiver where it was not supposed to be in the first place. This blade was supposed to have been disposed into the sharps litter box immediately after use, but that had not been the case due to the fact that the delivery had not taken place in a maternal ward and there was confusion all over in the darkness. As I started washing the receiver, I accidentally touched the surgical blade because it was dark and I was not seeing it. That was the time that I realised that the surgical blade which had been used to cut the umbilical cord from the baby was in the receiver where it was not supposed to be in the first place. I suffered a deep cut from which I started bleeding a lot. I was told to wash my finger on running water before dressing my finger. I completed my night shift two nights after before going off duty (nights off) for nine days. After coming back to work on a day shift, it was after my colleagues had asked me about how I got my finger injured that they informed me that I was supposed to have immediately taken prophylaxis medication to avoid HIV infection."

This outcome could have been avoided through in-house training and enforcement of this healthcare worker protection protocol.

6.4.6 Result area six: Human Resource Information and Research

Decision making authority on this area was aimed at the development of a comprehensive Human Resource for Health Information System (HRHIS), and research on human resources for health. The rationale was to help to support the Human Resource for Health Planning Process and other aspect of the Human Resource for Health Policy through a centralised information system and research.

6.4.6.1 Human Resource for Health Information System

The rationale behind this intervention was the creation of a computerised database system with up to date information about the numbers, skills, calibre and cadres of all healthcare workers at each health facility. This database was meant to become a health workforce

observatory through which the Ministry of Health and Child Care would monitor the healthcare worker establishment in all provinces, districts, communities and clinics to inform policy decision making on healthcare workers and the human resource for health planning process. Decision making on this was based on this new administrative norm and standard of healthcare worker management. However, it was also established that the lack of technical, financial and material resources meant that the implementation of this decision. As a result, monthly reports for the three clinics were prepared by the District Medical Office through manual paper based methods. These provided data on regular periods regarding the human resource for health situation at the municipal and mission clinics in Epworth.

6.4.6.2 Research

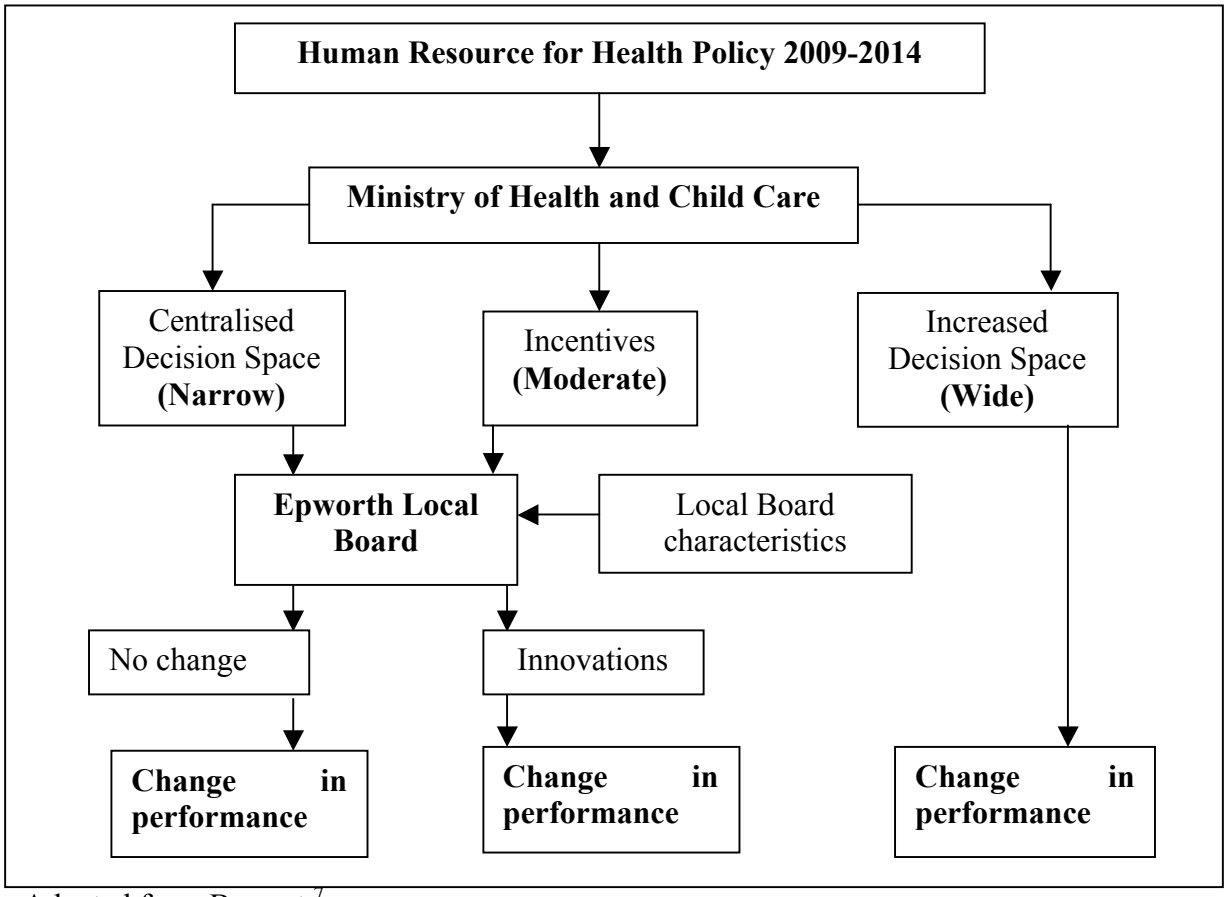
Decision making on research was aimed at ther generation of human resource for health data to inform the human resource for health policy. It was etablished that research was undertaken by the Ministry of Health, through the Provincial and District Medical Offices. The health ministry enjoyed technical capacity, oganizational authority, administrative and political legitimacy to carry out research. Research helped keep track of data on health personnel at the municipal and mission clinics, and for accountability purposes in the policy implementation process. As a result, research was undertaken by the Provincial Medical Directorate through the District Medical Office to support policy decision making at the district, provincial and national levels. In essence, the Local Board relied on the visible hand of the District Medical Office for updates and regular assessments. However, whilst the local board played a supervisory role on the local private sector, links with the public sector were weak. As a result, private clinics had their own research, and human resource for health arrangements.

CHAPTER SEVEN
DISCUSSION OF FINDINGS

7.1 TOWARDS HUMAN RESOURCE DECISION SPACE MAPPING ANALYSIS

This discussion was framed around the Principal Agent Theory in which the Decision Space Approach as outlined in Fig 7. The theory enabled the identification of the two main actors namely the principal, Ministry of Health, and agent, Epworth Local Board. Using the Decision Space Approach, it was possible to determine decision space; choices made by actors (Principal and Agent) in their decision space, including how the Ministry of Health (Principal) shaped incentives and punishments for the Local Board (Agent) towards bringing about desired policy outcomes (change).[7]

Fig 7: The Principal and the Agent



Adapted from Bossert.[7]

For each result area, the indicators used to measure the levels of decision space (wide, moderate or narrow) included: the role and authority of actors at different levels of decision

making; the political rule of the game (state's strategic interests based on political ideology); laws and regulations; administrative norms and standards; and capacity (financial, technical and human resource) to enforce decisions.[7]

7.2 HUMAN RESOURCE DECISION SPACE, INNOVATIONS AND IMPACT

7.2.1 The Human Resource for Health Decision Mapping Analysis Conceptual Tool

The conceptual tool, outlined in Table 16 was used to facilitate analysis towards determining how the human resource for health policy interventions of 2009 to 2014 impacted Epworth in Zimbabwe.[7] In this, focus was on six result areas of the Human Resource for Health Policy Function. These included: Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Labour Relations; Health and Safety; and Human Resource Information and Research. Using the Decision Space Approach, analysis sought to determine the amount of decision space transferred from the principal (Ministry of Health and other policy community actors at the national level) to the agent (local government institutions at the periphery), the decisions local officials made with their decision space around these six result areas, and outcomes in terms of the effect that these decisions had on the performance of the local human resource for health system in Epworth, Zimbabwe.[7]

Table 16: Human Resource for Health Decision Space Mapping Analysis Conceptual Tool

RESULT AREAS	RANGE OF CHOICE		
	Narrow	**Moderate**	**Wide**
1. Human Resource Planning and Financing			
• Demand and Supply Forecasting		MHCC;[x] ELB;[xi] Mission[xii]	Private clinics
• HRH Financial Budgeting		MHCC; ELB; Mission	Private clinics
• HRH Strategic Partnerships	MHCC		
2. Production, Training and Development			
• Capacity building for training critical HRH	MHCC; MHTE[xiii]		
• Support for further training	MHCC		Private clinics
• Centres of specialization	MHCC		
• Induction and exchange programmes	MHCC		Private clinics
3. Deployment, Retention, Utilization and Management			
• Deployment		MHCC; ELB; Mission	Private clinics
• Retention and motivation		MHCC; ELB; Mission	Private clinics
• Performance management and utilization	MHCC		Private clinics
4. Health Labour Relations			
• Rights framework	MHCC		
5. Health and Safety			
• Health welfare			MHCC; ELB; Mission; Private Clinics.
• Safety and protection	MHCC		
6. Human Resource Information and Research			
• HRH Information System	MHCC		Private clinics
• HRH Research	MHCC		Private clinics

Map idea adapted from Bossert 2000[7]

[x] MHCC is the Ministry of Health and Child Care through the Health Services Board.

[xi] ELB refers to the Epworth Local Board, which is the local municipal (local government) authority in Epworth.

[xii] Mission is a church owned but government run clinic. In this context, the mission was the Methodist Church Mission.

[xiii] MHTE refers to the Ministry of Higher and Tertiary Education underwhich universities and polytechnics fall.

7.2.1.1 Human Resource for Health Planning and Budgeting Decision Space

It was established that there were three sub-policy functions in this area that included human resource for health planning, budgeting and international strategic partnerships. There was *moderate decision space* in human resource for health planning for the two municipal clinics and one mission clinic. The level of decision space on human resource planning was determined by the capacity (financial, technical and human resource) of actors to make and enforce effective choices. Being a devolved municipality, the local board had a primary role of forecasting demand and supply of its healthcare workers, however because of capacity constraints, thjere was collaboration with the Ministry of Health through complementary intervention characterised by what Bossert referred to as *functional innovation* to help overcome capacity constraints on the part of local board and the mission.[7] In this, there was a shared responsibility effected through dialogue between the Local Board and Ministry of Health towards projecting the demand and supply of health personnel for the two municipal clinics and one mission clinic in Epworth. Whilst the Epworth Local Board made effort, it appeared that intervention by the Ministry of Health on this area was necessary and inevitable because it had limited technical and financial capacity to steer effort towards policy objectives. Intervention by the principal emanates from the fact that the local government system in Zimbabwe is a legislative rather than a constitutional creature. The main Acts for local governance purposes are the Urban Councils Act (Chapter 29:15), Urban Councils Amendment Act (Chapter 29:16), and the Rural District Councils Act (Chapter 29:13). In terms of these laws, local municipalities are not an independent sphere of government, but an appendage of central government. The Ministry of Local Government administers all the Acts and Statutory Instruments promulgated in the local government area. The Minister retains a substantial supervisory role over all local government units (LGUs) and enjoys the ultimate power of intervention in any local council.[32,33]

For instance, section 6 under PART II of the Urban Councils Act (Chapter 29: 15) makes provisions relating to the establishment and abolition of local boards. In sub-section 1, it is stated that whenever the President considers it desirable he may, subject to this Act, by proclamation in the Gazette, after any local authority concerned has been consulted, declare any area which is not within a local authority area to be a local government area and shall assign a name to that area. Sub-section 2 states that where a local government has been or is

being declared, the President may subject to this Act, establish a local board for that area and shall assign a name to that board, alter the name of the local board, alter the boundaries of the local board by adding thereto and additionally or alternatively, subtraction therefrom any area, determine any question arising from the addition or subtraction of such area and redefine the local government area, and abolish the local board established for that area. Sub-section 2 states that the Minister may, after consultation with the person and any local authority concerned, by statutory instrument, vest the administration, control and management of a local government area and any services provided by the State in that area in any person, and any regulations or by-laws in force in that area immediately before such vesting shall be deemed to be regulations made by the Minister and shall continue in force in that area until amended or repealed by the Minister. Further sub-section 4 provides that the Minister may from time to time, in respect of any local government area the administration, control and management of which are vested in a person other than a council, after consultation with that person, give directions or impose such conditions a he may think fit with regard to administration, control and management of such a government area, including the provision of services therein.[33] It appears that this was the basis upon which intervention was made through the Ministry of Health, towards human resource for health reform in Epworth Local Board. As a result, the Ministry of Health played a bigger role, mainly through its Provincial and District Medical Offices, towards determining the number and potential sources of health cadres with the kinds of skills, knowledge and attitudes required. It has been note that intervention and collaboration impacted somewhat positively on the local human resources for health system. To start with, human resource planning, which had literally ceased in the midst of the socio-economic challenges of pre 2009, became functional again. This somewhat contributed towards reducing the gap between the projected demand and supply of healthcare workers between 2009 and 2014.

However, it is worth noting that government intervention exposed the Local Board and Mission to what Bossert refereed to as *the risk of sanction* through possible take over for failing to innovate, build technical and financial capacity, and sustain themselves.[1] Whilst these facilities remained under the ownership of the Local Board and Mission respectively, such ownership appeared to be in principle only. In practice, it appeared that the Ministry of Health had literally took over the human resource planning function to a far much greater extent. However, whilst the risk of sanction through take over by the principal appeared

politically lucrative, it also appeared contestable due to the political standing of the Local Board as a devolved local authority. In addition, there were other competing interests and priorities that also competed for the principal's limited financial purse.

In contrast, the local private clinics enjoyed *wide decision space* in human resource planning as their operations were parallel to those of the local public sector.[7] They were guided by their financial capacity towards estimating the number of professionals and the kinds of skills, knowledge and attitudes required, and their potential sources. As a result, this allowed private clinics to innovate even though the extent to which they could do so was determined by their financial capacity. However, it has been noted that this capacity was limited by a narrow revenue base due to fewer clients in an impoverished community whose overwhelming majority could not afford private medical care. It appeared that this accounted for their much smaller size and operational functions even though they presented a complementary and alternative health care service delivery channel for locals in this community. From this, it was established that between 2009 and 2014, the total number of Private clinics in this peri-urban community grew from three to seven.

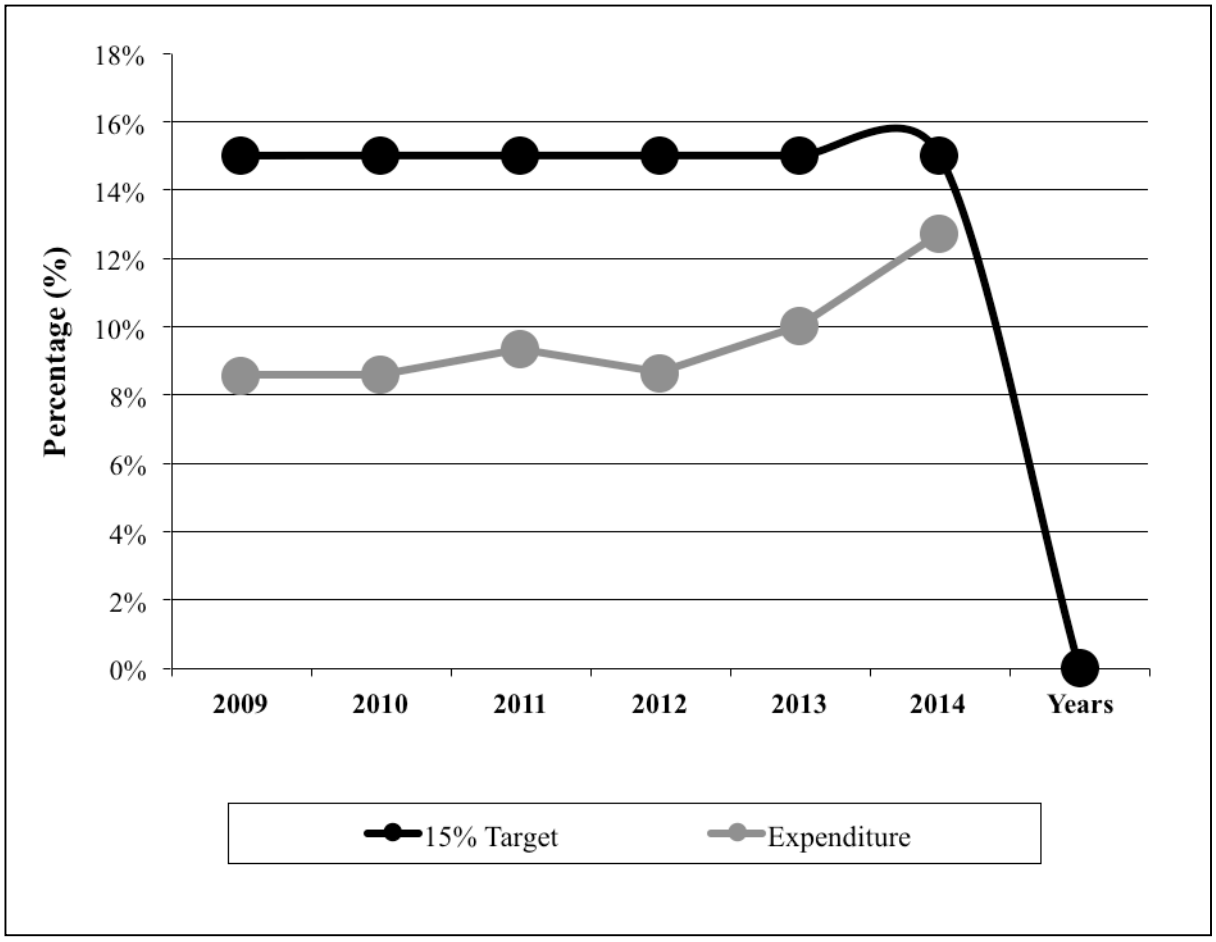
Budgeting was another policy sub-function where decision space between the principal and agent was shared towards human resource for health reform. Financial capacity of actors was a determinant of decision space between the principal and agent in financial planning for human resources for health. As outlined in Table 16, there was *moderate decision space* in financial budgeting for local health personnel in Epworth between 2009 and 2014. It was characterised by *functional innovation* through complementary but parallel budget structures between the Local Board, the Health Ministry, and Mission.[7] On one side, the Ministry of Health *innovated functionally* by intervening to pay salaries of health personnel at the two Municipal clinics and one Mission clinic from its share of the national budget, implemented in the contect of the Finance Act (Chapter 23: 04). On the other side, the Epworth Local Board was a devolved local municipal authority which had its own budget implemented it terms of the Urban Councils Act (Chapter 29: 15).[33] In addition to the payment of top-up allowances, the Local Board also used its moderate space to help finance the provision of sundries to support health personnel and payment of salaries for two Nurses, two Nurse Aids and four Security Guards. It has been mentioned that there was an increase in the proportion of the local board's budget allocated towards health personnel.

Whilst there were enabling factors for this increase, it was noted that the local budget remained inadequate to meet salaries and top-up allowances for all health personnel at these two clinics. This was attributed to a narrow local revenue base, impoverishment, immigration, semi-formal settlement and other competing local policy priorities. As a result, the Local Board remained dependent on the Ministry of Health for the payment of salaries. This scenario also exposed the Local Board to what Bossert refereed to as the *risk of sanction* either by way of either central government take-over.[7] In addition to this, the Mission in Epworth also had its own budget through which it engaged in *functional innovation* towards the payment of top-up allowances to help supplement salaries paid to staff at its clinic by the Ministry of Health. However, it appeared that *functional innovation* by the Mission was not effective because it created a sense of selection, division and exclusion amongst health personnel.[7] This is because the Mission only managed to pay top-up allowances for only four Nurses, four Nurse Aids and one Environmental Health Officer who had worked at its clinic before 2009. As a result, the other four Nurses deployed by the Ministry of Health to help complement the local staff establishment at the Mission clinic after 2009 did not receive any top-up allowances. It appeared that the Mission was financially constrained as it also struggled to provide sundries such as washing soap to support health personnel at its clinic between 2009 and 2014. On this matter, concerns were raised by health personnel at the Mission clinic who complained about how the withdrawal of certain sundries was negatively affecting their work.

The unfavourable financial situation in the local human resources for health system was compounded by national budgetary constraints that also undermined the extent to which the Ministry of Health could intervene. These constraints manifested at a national level where the budgetary allocations on health from the share of the national budgets from 2009 to 2014 fell short of the 15% minimum requirement. These gaps had negative implications on the extent to which it could successfully intervene in Epworth. In this context, expenditure made for health from the share of the National budget did not reach or exceed the 15% minimum requirement set out in the 2000 Abuja Declaration.[60] In 2009 expenditure was 8, 56% of the proposed US$1, 9 billion proposed National Budget.[53] This proportion was just above half of the 15% requirement. Expenditure slightly improved to 8, 58% from the proposed National Budget of US$ 2, 25 billion in 2010, and then to 9, 33% of the proposed National Budget of

US$2, 7 billion in 2011.[54,55] In 2012 however, the proportion of expenditure however dropped to 8, 64% of the proposed National Budget of US$ 4 billion.[56] In 2013, this proportion of health expenditure rose to 10% of the proposed National Budget of US$ 3, 8 billion, before peaking at 12, 7% of the proposed US$ 4, 12 billion 2014 National Budget.[57,58,59] Fig 8 outlines a summary of these expenditure gaps.

Fig 8: Summative analysis of expenditure gaps on health from share of National Budget between 2009 and 2014



Adapted from Ministry of Finance and Economic Development[53-59]

It seems as though the upward trend in expenditure towards the 15% threshold was indicative of government takeover of healthcare funding from international donors following the 2013 Harmonized Elections at which a the government initiated the implementation of its electoral agenda through the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim-Asset). Zim-Asset was a socio-economic blue print which promoted pro-indigenization and inward policies advocating for self sustaining economic growth. However, the failure to

meet the 15% health expenditure requirement suggested financial gaps which undermined the implementation of the human resource for health policy interventions in Epworth. Further inquiry on this matter suggested that principal also had other competing macro-economic policy interests as articulated in the Staff Monitored Programme by the Government and the International Monetary Fund (IMF) which somehow accounted for limited funding.[61] It is worth noting that funding towards health increased from 2013 onwards because the government was taking over responsibility from international NGOs in areas where it had received donour assistance. As a result, there was the freezing of public health sector recruitment whist only allowing some limited flexibility in filling critical vacancies that could not be filled through internal mobility so as to avoid expanding expenditure.[56] In practice, this seemed to undermine the ability to supply funding for more healthcare workers in Epworth, the effect of which was inadequate numbers of healthcare workers at Municipal clinics and the Mission clinic, which depended on the government for healthcare worker funding. In addition, it also seemed to contribute towards perceived inadequate remuneration for healthcare workers employed by these organizations which also undermined healthcare worker morale. In a bid to overcome these financial and technical constraints, the Ministry of Health used its space to innovate by engaging its international Human Resource for Health Strategic Partners in the context of the Zimbabwe United Nations Development Assistance Framework (ZUNDAF). As a result, it entered into a strategic partnership which facilitated a programme specific intervention on TB and HIV/AIDS by an international Non Governmental Organization (NGO) in Epworth.

These international strategic partnerships were an intervention meant to mobilise financial and technical resources towards complementing government effort in the implementation of the 2009 Human Resources for Health Policy. Between 2009 and 2014, they were also a source of temporary relief aid which facilitated the resuscitation of the local human resource for health system. Decision space on this aspect was determined by the state political rules of the day that reflected on the ideology and interests that provided strategic direction to the country's foreign policy. As a result, decision space on this aspect was narrow as there was centralised directed action determined by the country's international health relations at a political level.[7] From this, a programme specific partnership on HIV/AIDS and TB was entered into with an international Non Governmental Organization in 2007. Given the severity of the HIV/AIDS situation, the international NGO implemented programmes to

intervene in this community, whilst the government used resources generated from the National AIDS Trust fund to intervene in other parts of the country through the National AIDS Council. This organization complemented government effort towards the revitalization of the local human resources for health system in Epworth between 2009 and 2014, whilst enabling gradual transfer of responsibility and scaling down of operations during this period.

In addition, it also facilitated community enagement in health through the revival of the Village Healthcare Worker Programme/ Community Health Volunteers Initiative. This programme had been initiated in November 1981 in the context of the Plan for Equity in Health (1981-1984), and the First Health for all Action Plan of 1985 to 1990 but had only existed in principle and rarely in practice over the years due to a number of factors. The first relates to the tendency towards *non-decisions* due to resource constraints in which it seemed attention shifted towards other more pressing priorities of the time that followed.[62] Amongst these included economic inefficiency which resulted in mounting public debt of the 1980s, national austerity measures of the 1990s implemented in the context of the Economic Structural Adjustment Programme (ESAP) and socio-political and economic challenges of the first eight years of the new millennium characterised by the worst ever, world record breaking rate of inflation which peaked in 2008 literally crippling the health system.[17] As a result of these developments, it seemed decision making on the implementation of the Village Health Worker Programme was undermined, particularly in peri-urban communities. The second factor relates to what other scholars pointed out as tendencies towards bureaucratisation and centralisation of health policy implementation in Zimbabwe, which was alleged to be a reflection of a *de-facto* inadequate support for primary health care by the government.[16] Regardless of whichever way one looks at it, one cannot doubt resource constraints as the barrier which had undermined this programme over the years, and the potential contribution of community engagement towards human resource for health reform in resocurce constrained settings.

7.2.1.2 Decision Space on Production, Training and Development

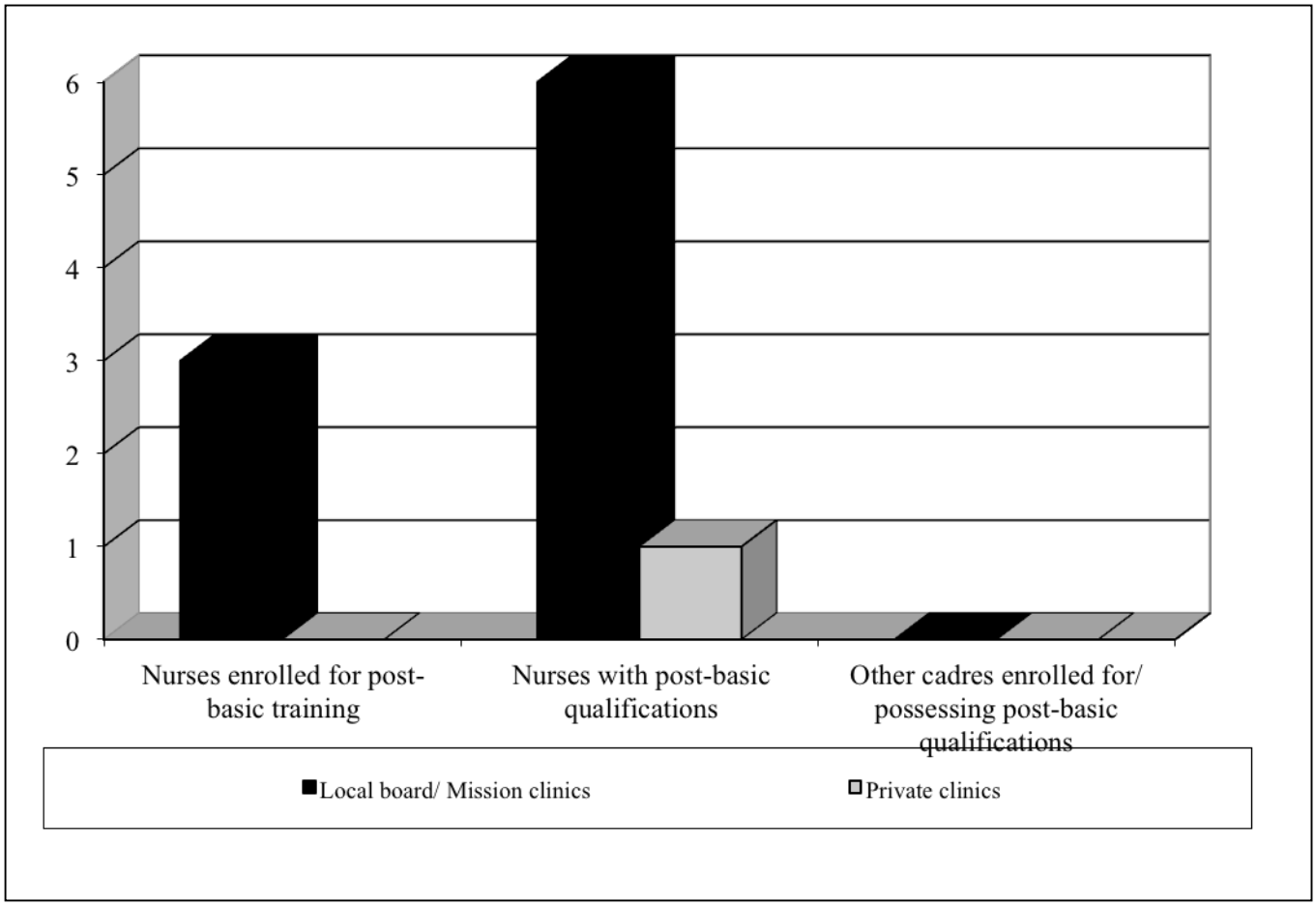
In this policy result area, it has been established that the sub-policy functions included capacity building for training critical human resources for health, support towards post basic training, establishment of centres of specialization, induction and exchange programmes. Capacity strengthening for training critical human resources for health was guided by the

Ministry of Health's administrative norms and standards towards healthcare worker development. As a result, there was *narrow decision space* as decision making authority was made at a principal level by the Joint Planning Committee that consisted the Health Services Board of the Ministry of Health and Child Care, and the Ministry of Higher and Tertiary Education.[7] These were ministries under which healthcare worker training institutions upon which capacity strengthening was undertaken fell. The committee provided strategic direction and regulation to all these training institution in the capacity building process. As a result, the institutions were able to produce more healthcare workers to the point that they could no longer be absorbed into the health service due to restrictive policy requirements on healthcare worker recruitment, and financial constraints.

Apart from this, healthcare workers in the civil service were provided support to enrol for post basic training to pursue post-basic Diploma, Higher National Diploma, Degree and on the job training. The decision to support health personnel was made by the Ministry of Health and Child Care, and the Ministry of Higher and Tertiary Education. Decision space on this aspect was *narrow* as this support was based on administrative norms and standards of the Ministry of Health, and the Ministry of Higher and Tertiary Education. These principal level actors were guided by priorities of the government on healthcare worker training and resource availability.[7] On this, one medical respondent expressed appreciation for the support they received from the DMO's office to pursue post-basic and postgraduate qualification. However, other respondents were concerned about the lack of opportunity to pursue further training particularly in areas of their choice. As a result, it was established that some healthcare workers were considering leaving the profession as a result of frustration due to lack of opportunity alltogether. Further compounding this were staff shortages and complains of a heavier workload experienced by others who would remain behind to fill the void left by others who would have gone on study leave. It was established that all these factors contributed towards the low numbers of health personnel who possessed post basic qualifications, or were enrolled for post basic training during the period of 2009 and 2014. Whilst private clinics enjoyed wide decision space on this area, support and opportunities for health personnel at the private clinics in this community were also limited, few, far in between and in some cases non-existent as they depended on their employers. This had an undermining effect on post-basic training for healthcare personnel in the local human resource for health system. This scenario was componded by the fact that healthcare workers

from the local private sector, and non-medical personnel such as Nurse Aides were often left out from attending regular on the job training workshops conducted to counter the limited opportunties for post-basic training. As outlined in Fig 9, the proportion of nurses who managed to enrol for post basic education and support to pursue them between 2009 and 2014 was only three out of a total of 59 nurses in the community. Of these three, two were employees at the Municipal clinic whilst one was employed by the Mission.

Fig 9: The number of nurses enrolled for and/or possessing post-basic qualifications



Source: Fieldwork dataset

However, regardless of these challenges, it was established that training impacted positively towards addressing the community's main health challenges which included Cholera, HIV/AIDS and TB. For instance, it was established that Cholera was completely eradicated during the period 2009 to 2014 as a result of the training on water and sanitation. Before 2009, it was established that HIV/AIDS and TB had been the main cause of motarlity in Epworth. It was also established that HIV/AIDS and TB interventions had become literally non-existent due to the unfavorable socio-economic situation which peaked in 2007 and

2008. Comparatively however, between 2008 and 2013, significant progress was made towards fighting this disease as more patients were tested for HIV/AIDS, initiated on ART and being put on TB treatment in 2013. There was a total number of 8 712 HIV tests done in 2013 compared to only 1 964 in 2008. The number of patients initiated on antiretroviral treatement increased from 370 in 2008 to 1 762 in 2013, whilst the number of TB patients put on treatment increased from 391 in 2008 to 494 in 2013. It was noted that most locals were reluctant to seek to know or reveal their HIV status because of the fear of stigma. As a result, only 491 people that tested positive in 2008. The low number is an understatement of the actual figures because most people who suspected that they were HIV positive were reluctant to come forward to confirm their status or sought services in other areas to avoid the stigma associated with their HIV positive status. However, as a result of intervention by the Ministry of Health through the international NGO, and local board and mission clinics, there was a significant reduction in stigma which resulted in 2 407 people testing positive and 1 762 of them being initiated in antiretroviral treatment.

The establishement of centres of specialization was also another result area. For Epworth, decision space on this aspect was *narrow* as this support was based on administrative norms and standards of the Ministry of Health.[7] Centralised and directed change on this area was vested in the Provincial Medical Office. However, between 2009 and 2014, it appeared this office experienced financial and technical challenges that undermined the establishment of centres of establishment in the province. As a result, the province relied on output from training institutions such as Parirenyatwa School of Nursing and the College of Health Sciences at the University of Zimbabwe. Apart from this, **t**here was *narrow decision space* towards the implementation of induction and exchange programmes as it was based on administrative norms and standards of the Ministry of Health.[7] Decision making on this was centralised and undertaken at the provincial level. However, financial constraints at the principal level undermined the implementation of decisions on this result area. Consequantly, it was established that there were no standardised measures developed for the induction and exchange programmes for healthcare workers in this province underwhich Epworth fell.

7.2.1.3 Decision Space on Deployment, Retention and Performance Management

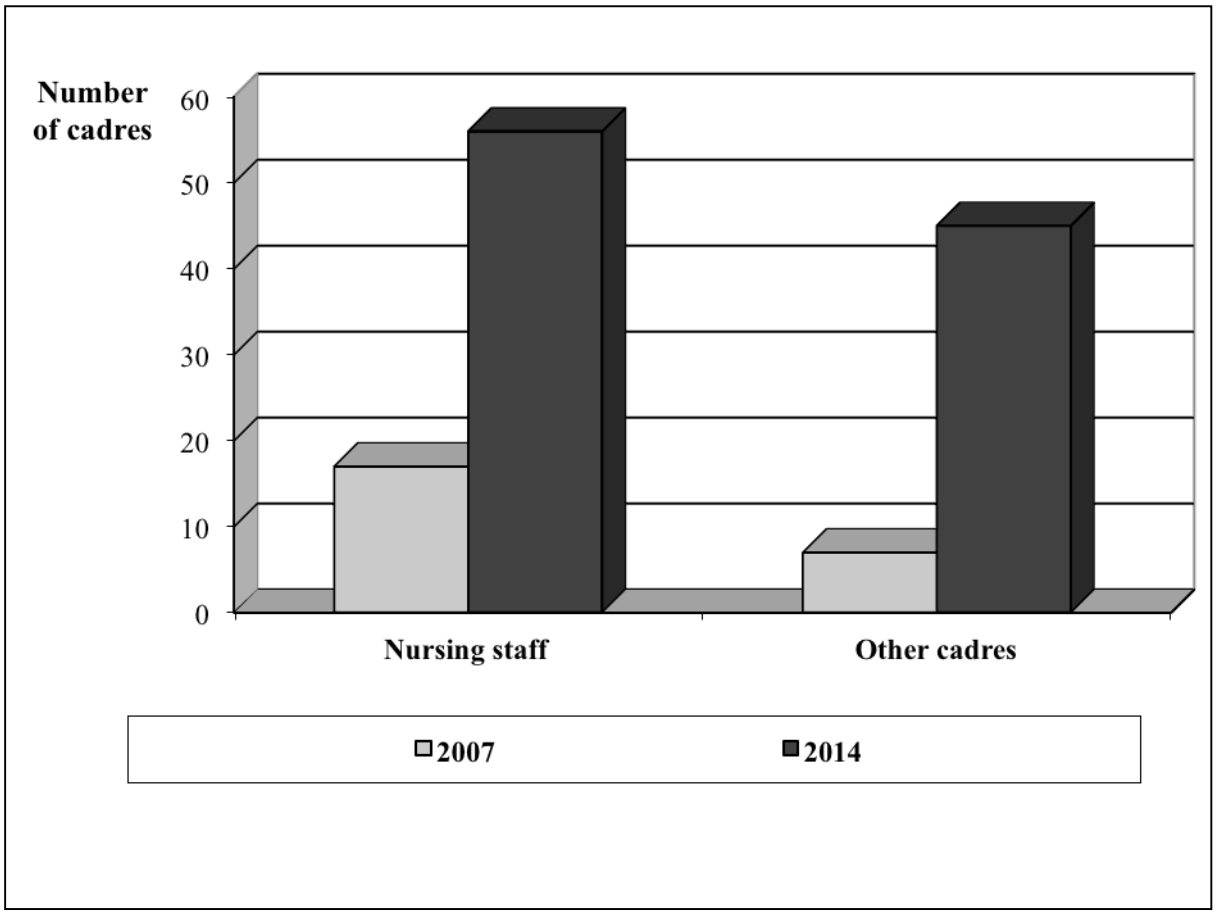
The results expected on this policy area were to attain effective healthcare worker deployment, retention, utilization and management. There was *moderate decision space*

towards the deployment of healthcare workers at the two municipal clinics and mission clinic as outlined in Table 16.[7] Decision space was determined by financial and technical capacity between actors. Financial and technical incapacity on the part of the Local Board and Methodist Mission meant that assistance by the Ministry of Health towards healthare worker deployment was necessary. As a result, the Ministry of Health and Child Care intervened through its District and Provincial Medical Offices to help complement local effort. From this, there was an 229% increase in the total number of nursing staff[xiv] (Registered General Nurses, Midwives, State Certified Nurses, Primary Care Nurses) from 17 in 2007 to 56 in 2014. 45 of these Nurses in Epworth, were were on the civil service payroll whilst the rest were employed by the local private sector. The number of other cadres[xv] (Nurse Aides, Environmental Health Officers, Primary Counsellors, Pharmacy Technicians, Dispensary Assistants, Pharmacy Technicians, Ambulance Drivers, Laboratory Scientists) also increased by 542,8% from 7 in 2007 to 45 in 2014, with 32 of them being on the government payroll. The increase in the number of cadres in outlined in Fig 10.

[xiv] Nursing staff are medical cadres qualified to provide direct patient care. They included Registered General Nurses, Midwives, State Certified Nurses, Primary Care Nurses.

[xv] other cadres are support staff who provided indirect patient care. They included Nurse Aides, Environmental Health Officers, Primary Counsellors, Pharmacy Technicians, Dispensary Assistants, Pharmacy Technicians, Ambulance Drivers, Laboratory Scientists.

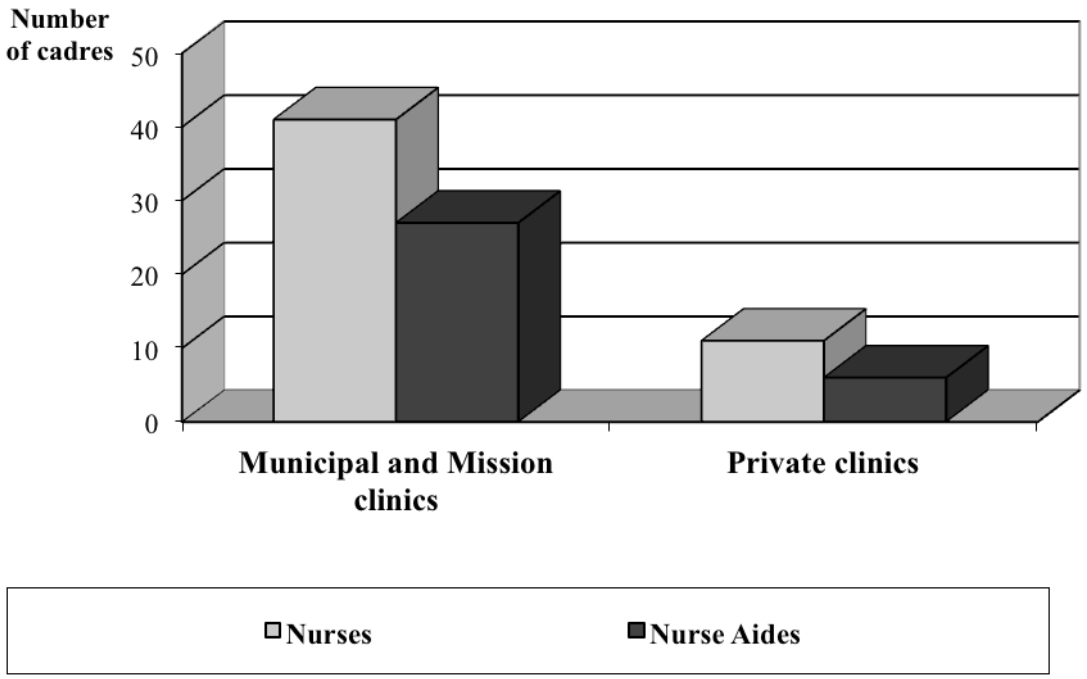
Fig 10: Increase in the number of nurses and other cadres between 2007 and 2014



Fieldwork dataset

It is important to note that the percentage increase in the number of health cadres was greater than the population increase between 2002 and 2012. In 2002, Epworth's average population of 141 067 grew by 15% to 161 840 by 2012.[63] This implies that the increase in the number of health personnel was significant and notable. It has been noted that the the number of healthcare workers at the mission clinic increased from only 4 Nurses and 3 Nurse Aides in 2007 to 8 Nurses, 4 Nurse Aides, 2 Primary Counsellors and 1 Environmental Health Officer in 2014. There was also a pool of about 30 Community Health Volunteers deployed in the capacity of either Village Health Worker/Community Health Volunteer or Peer Educators which also added to this pool. In addition, local private health sector participation was enhanced through the issuing of operating licences by the local authorities. As a result, the local private health sector contributed 11 out of the 56 Nurses, and 6 out of the 27 Nurse Aides as illustrated in Fig 11 below.

Fig 11: Sector contributions towards the local human resource for health system



Sector contributions towards the local human resource for health system: The number of Nurses and Nurse Aides contributed by Municipal and Mission, and Private clinics in Fieldwork dataset

It was also noted that the local private sector also contributed 7 Medical Practitioners (Doctors) who operated these clinics, which also provided an additional option for higher level health care in this local context. To some extent this helped counter the unavailability of Medical Practitioners (Doctors) at the two municipal clinics and one mission clinic, and barriers associated with programme specific Medical Doctors from the international NGO who only attended to HIV/AIDS and TB patients at this clinic and the community. However, it must be noted that there were also barriers that undermined access to services provided by Medical Practitioners (Doctors) at the local private clinics. Amongst these included the consultation fees and fixed operating times of the day which made their services out of reach to most members of the community.

Nevertheless, collaborative effort between the Principal and Agent towards the deployment of healthcare personnel resulted in improved availability of human resources compared to the situation before 2009. Epworth had a physician to patient ration of 0,08: 1000. This ratio included the 7 General Medical Practitioners who operated private clinics in the community and 6 Programme Specific Medical Doctors from the international NGO.

Table 17: The Physician and Nurse to Patient Ratios

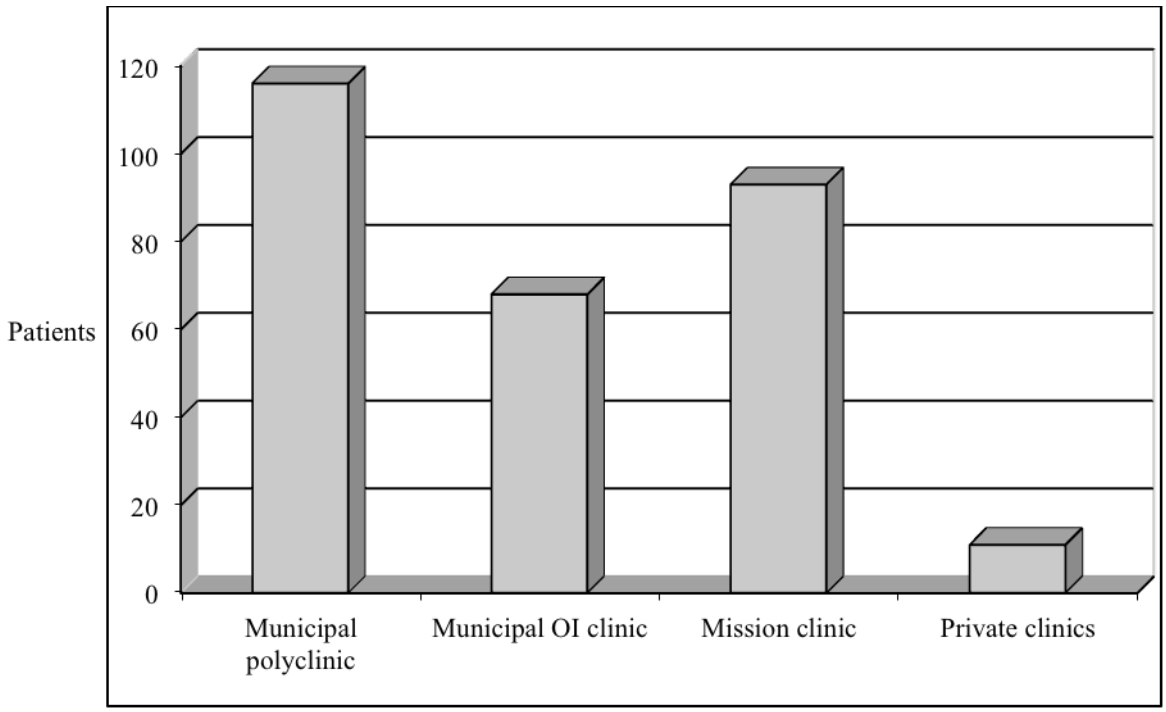
Cadre	Number	Average population size for Epworth	Epworth (2014)	Zimbabwe	WHO physician to patient standards
Doctors: (7 General Medical Practitioners and 6 Programme Specific Medical Doctors)	13	161 840	0.08: 1000 (Physician to Patient Ratio)	0,06: 1000 (Phycisian to Patient Ratio) **(2009)**	2, 3: 1 000.[64]
Nurses: (Registered General Nurses; State Certified Midwives; Primary Care Nurses).	56	161 840	0,35: 1000 (Nurse to Patient Ratio)	1 ,3: 1000 (Nurse to Patient Ratio) **(2011)**	5: 1000.[64]

Fieldwork dataset

At face value, it appears that this was a notable improvement because this physician to patient ratio compared favourably against the ratio of 0, 06: 1000 in the rest of Zimbabwe in 2009, Tanzania's ratio of 0, 03: 1000 (2012), 0, 04: 1000 in Mozambique (2012), 0, 06: 1000 in Rwanda (2010), and 0, 02: 1000 in Malawi (2009).[64] However this improvement is debateable when other factors are put into consideration. Amongst these include the fact that there were no permanent physicians (Doctors) at the two municipal clinics and mission clinic, which relied on the 6 programme specific Doctors who were always ready and to provide assistance in critical health situations outside of their programme if the situation allowed. This had negative implications towards universal health coverage towards which the human resource for health reform was meant to contribute. Compounding this were barriers to access the 7 physicians who operated local private clinics. As a result, locals had no choice but to congest the public clinics for basic medical care, and attention from the programme specific physicians from the international NGO, if possible, in case of emergencies. This was a concern considering their heavy workload too and also the fact that their organization was in

the process of scalling down operations in this community. In addition, the situation also looked less favourable when the phycisian to patient ratio was compared with that of other countries in the region. Amongst these included Botswana which had a physician to patient ratio of 0, 4: 1000 (2010), Angola's 0, 17: 1000 (2009), Kenya's 0, 2: 1000 (2013), Zambia's 0, 17: 1000 (2012), South Africa's 0, 78: 1000 (2013), 1, 62: 1000 (2013) in Mauritious, and 1, 78: 1000 in Seychelles (2012). Further, the World Health Organization estimates that fewer than 2, 3 health workers (physicians, nurses and midwives only) per 1000 would be insufficient to achieve coverage of primary healthcare needs. Further, the nurse to patient ratio of 0, 35: 1000 of 2014 compares less favourably to that of 1, 3: 1000 for the rest of Zimbabwe in 2011.[65,66] This implied a shortage of Nurses which still persisted in this community by the end of 2014. These shortages manifested by way of a heavy workload of healthcare workers at the two Municipal clinics and one Mission clinic. It was observed that these clinics congested with patients for most parts of each day and provided services to a whole lot more patients in this community compared to the private clinics. For instance, it was established that established that a Nurse at the largest and oldest local municipal clinic located at Domboramwari business and administrative area attended to an average of 116 patients each day during this period, as outlined in the Fig 12 below.

Fig 12: Mean number of patients attended to by a Nurse per day by facility type



Fieldwork dataset

It was established that there were strategies put in place to help cope with these numbers. The operating arrangement was that Peer Educators would pull files for patients as soon as they arrive. Nurse Aides would then check for vital signs such as blood pressure and temperature before dispatching patients to relevant departments for medical attention by Nurses before being discharged through the dispensary department. In addition, there was a flexible work arrangement in which Nurses from the less busier departments would go to provide assistance in the more busier departments as soon as queues in those departments clear up. It was observed at this clinic that for most of the days, services in the outpatients section would continue to be provided even beyond working hours until everyone had been received medical attention. The arrangement was almost similar at the other two clinics (municipal and mission) where it was established that Nurses attended to an average of 68 and 98 patients per day respectively. However, it was established that all the nurses at the two municipal clinics and one mission clinic complained of a heavy workload to the effect that a few revealed that they were taking anti depressants to cope with the stress and burnout. This also seemed to affect the quality of service delivery at these facilities as it was established from community members that the quality of service delivery that had improved significantly immediately after 2009 had started deteriorating after 2013. Further compounding these shortages was that the implementation of the Community Health Volunteers Initiative, that had been revitalised to help counter healthare worker shortages, was been undermined by capacity constraints that included the unavailability of adequate financial, human resource and material resources. This had negative implications towards human resource for health reform and universal health coverage.

Apart from the deployment of healthcare workers, there was also decision making effort towards retaining healthcare workers. Decision space on this policy result area was determined by financial and technical capacity of actors. As a result, there was *moderate decision space* towards the implementation of healthare worker retention decisions. In this context, the Ministry of Health intervened to provide the *incentives to entice* to the local board and the mission towards healthcare worker retention.[7] It was established that the Ministry of Health intervened to pay the salaries for healthcare workers at the two municipal clinics and one mission clinic to help counter financial incapacity and enable healthare workers to come to work on these clinics. However, it appears that this incentive by the

ministry only achieved desired outcomes to a limited extent as most healthcare workers expressed lack of satisfaction with their salaries. Amongst the sources of dissatisfaction included inadequate salaries, the salary grading system which did not take into account their qualifications and risk factors in their work. To help counter this, it was established that the Local Board and the Mission engaged in *functional innovation* from which they complemented central government effort through the payment of a monthly top-up allowance to healthcare workers at the two Municipal clinics and Mission clinic.[7] However, whilst this intervention helped supplement salaries, some of the healthcare workers at these facilities did not receive the top-up allowance. For instance, it has been established that top-up allowances were paid to only 4 Nurses and 3 Nurse Aides at the mission clinic. The remaining 4 Nurses, 1 Nurse Aide, 2 Primary Counsellors and 1 Environmental Health Officer did not receive the top-up allowances. This scenario created a strong sense of exclusion and division amongst healthcare workers, and undermined morale.

The provision of other incentives that included free residential stands and free accommodation did not help this situation much as they were enjoyed by only few healthcare workers, as a benefit for long service. The scenario was further compounded by the withdrawal of certain benefits that included uniforms, a jersey, soap for washing, school fees for their children and free lunch at the workplace. Further, the majority indicated that their transport allowance did not compare with the actual cost of transport which was said to be double the requirement as they do not live in the Epworth. As a result, it was established that some Nurses took up jobs at other clinics where they worked after work or during weekends, whilst other were taking anti-depressants to cope with the pressure associated with unfavourable remuneration. The local private health sector enjoyed *wide decision space* in the implementation of healthcare worker retention strategies.[7] However it was established that the salaries in this sector were much lower than the local public health sector and that there were no benefits that included opportunities for training and development or a paid study leave. It was established that most of the healthcare workers in this category were in it either as secondary employment, just to gain some working experience or because it was the only job available to them at that time. A summative overview of the benefits received by healthcare workers from their employers is outlined in Table 18.

Table 18: Benefits received from all employers in the public and private sectors

Benefits	All (N=87) n (%)	Medical staff N = 47 n (%)	Non-Medical staff N = 40 n (%)
Housing allowance	60 (69.0)	36 (76.6)	24(60.0)
Protective clothing	42 (48.3)	17 (36.2)	25 (62.5)
Donor allowance	39 (44.8)	29 (62)	10 (25.0)
Top-up allowance	35 (40.2)	24 (51)	11 (27.5)
None	13 (14.9)	2 (4.3)	11 (27.5
Food at work	6 (6.9)	3 (6.4)	3 (7.5)
Transport to workplace	16 (18.3)	0 (0)	16 (40.0)
Stand	3 (3.4)	1 (2.1)	2 (5.0)
Transport allowance	3 (3.4)	2 (4)	1 (2.5)
Other	3 (3.4)	0 (0)	3 (7.5)
School fees loan	3 (3.4)	0 (0)	3 (7.5)
Airtime	2 (2.3)	2 (4.3)	0 (0)
Free accommodation	1 (1.1)	1 (2.1)	0 (0)
Building loan	1 (1.1)	0 (0)	1 (2.5)
Study loan	1 (1.1)	0 (0)	1 (2.5)
Medical aid	1 (1.1)	0 (0)	1 (2.5)

Fieldwork dataset

It was established that 60 healthcare workers received housing a housing allowance from their employer. Of these, 36 were medical personnel whilst 24 were non-medical personnel. In contrast however, only 1 of the respondents indicated that they had received free accommodation, a building loan, study loan or medical aid. 13 healthcare workers, 2 of whom were medical personnel in the local private sector indicated that they had received no other benefit at all. However, despite these interventions, it appears these impacted less successfully towards healthcare worker retention. Most healthcare workers in this community indicated lack of satisfaction with their working conditions and considerations to leave their jobs. Some indicated plans to leave their profession. This had negative implications towards the sustainability of the human resource for health reform effort. However, appears that

limited opportunities elsewhere appeared to be the only factor that indirectly contributed to the retention of healthcare workers.

Performance management was also another policy result area. Decision space on this area was *narrow* for healthcare workers on the civil-service payroll. Decision space was determined by administrative norms and standards of the Ministry of Health and Child Care.[7] As a result, it was undertaken by the Ministry of Health through the Provincial and District Medical Offices. To help facilitate this, the Ministry of Health and Child Care proposed the Results Based Performance Management System. However inquiry at the Provincial Medical Office revealed that this system was not taken up due to lack of technical capacity. As a result, there was continued to use the Performance Appraisal Form developed by the Public Service Commission (PSC) before 2009. It also appeared that performance management was overshadowed by staff shortages, and the visibly overwhelming workload which had an overstretching effect for staff in a high pressure environment. For healthcare workers at private clinics, decision space was *wide* and it was established that performance management took place through mutual discussion and advice between the facility manager/ owner and the healthcare worker.[7]

7.2.1.4 Health Labour Relations Decision Space

There was *narrow decision space* on this aspect as everything was defined by the law of the land for all healthcare workers in this peri-urban community.[7] The rights of the employer and employees were provided for in legislation that include Section 29 of the Constitution of Zimbabwe which made health a right for every citizen, and Statutory Instrument 88B of 2005. The Health Service Act (Chapter 15:16 No. 28/2004), made provisions for the establishment of the Health Service Board and its functions, to constitute the Health Service and to provide for its administration and the conditions of service of its members, and to provide for the transfer of persons engaged in public health service delivery from the Public Service to the Health Service. This Act was also aligned with the Health Professions Act (*Chapter 27:19*); Medical Services Act No. 27 of 1998, Public Health Act (*Chapter 15:09*), and Labor Relations Act (Chapter 28: 01). The Health Services Board to address complaints made by members of the health service and resolve conflicts between employers and employees.[26,29,31] The Labour Act (Chapter 28:01) also governed relations between the state, employers and employees in this regard.[31] In addition, the Public Health Act (Chapter 15:09) which made provisions for the establishment of the Health Ministry, District Health Management Committees, Local Health Authorities, Health Committees and duties thereof.[27]

Apart from this is the Medical Services Act (Chapter 15:13) governed the establishment of health facilities at all levels of society.[28] There was also the Health Professions Act (Chapter 27:19) made provisions for the establishment of the Health Professions Authority of Zimbabwe and councils for practitioners.[30] However, it was established that the centralized nature of the framework, and the difficult economic situation that prevailed made healthcare workers apathetic towards health labour relations as they were more concerned about their economic survival. All the other pieces of legislation however played an important role of formalizing employment terms and conditions in the health sector.

7.2.1.5 Health and Safety Welfare Decision Space

It was established that there were two result areas in this policy area, namely health welfare and safety. Decision space on the health welfare of human resources for health was *wide* for all healthcare workers at the clinics who were free join a medical aid scheme of their own.[7] Decision space was determined by the rules and regulations. Provisions relating to the health welfare of municipal healthcare workers are made in section 147 under Part IX of the Urban Councils Act (Chapter 29: 15). In this section, it is stated that subject to such terms and conditions as the Local Government Board, in consultation with the Minister and the Minister responsible for finance, may fix, a council may contribute to any medical aid society, sick fund or similar institution in respect of any of its employees or former employees; or the spouses, surviving spouses or other dependants of any of its employees or former employees; establish and maintain a sick fund or make such other provision as may be necessary to secure for such persons the benefits normally provided by a medical aid society; and pay the medical expenses of any employee of the council who suffers injury.[33] However, it appeared that the local board lacked financial capacity to establish a medical fund or a subsidised medical aid scheme to enable healthcare workers and their families to access medical care. This was compounded by the reluctance to join medical aid schemes by healthcare workers because of the effect that it would have on their low salaries. It appeared that the option available if need be was to access services for free at the clinics at which they were employed, just like any other member of the public. However, it was further realised that healthcare workers were likely to suffer in the event that they required complicated treatment procedures that might not be readily available in the community.

On safety and protection, decision space was determined by the clinical procedures and standards set by the Ministry of Health and Child Care, in line with the World Health

Organization Requirements. As a result, decision space on this aspect was *narrow*. However, it appeared that *narrow decision space* undermined training and enforcement amongst non-medical personnel particularly Nurse Aides who were often excluded from in-house training workshops on current healthcare worker protection protocols.[7] This undermined knowledge levels to respond effectively to some emergency situations such as accidental exposure or infection. A case in point was the infection of a Nurse Aide at one public clinic who did not administer Prophylaxis on herself within the stipulated time period of 72 hours after accidentally exposing herself to HIV infection. The infection of this healthcare worker was avoidable through in-house training and enforcement of this healthcare worker protection protocol. This case has implications on other non-medical healthcare workers too. It appears that desired outcomes of narrow decision space are only realised through enforcement at the agent level.

7.2.1.6 Human Resource for Health Information and Research

There were two main policy result areas namely human resource for health information and research. The first was aimed at the establishment of a computerised database (Human Resource for Health Information System) with up to date information about the numbers, skills, calibre and cadres of all healthcare workers at each health facility. This database was meant to become a health workforce observatory through which the Ministry of Health and Child Care would monitor the healthcare worker establishment in all provinces, districts, communities and clinics to inform policy decision making on healthcare workers and the human resource for health planning process. Decision space on this area was determined by administrative norms and standards set by the Ministry of Health in line with post 2009 Human Resource for Health Policy towards health system reform. A a result, decision space on this area was *narrow,* as outlined in Table 16 above.[7] However, it was also established that the lack of technical, financial and material resources undermined enforcement of choices made in this decision context. As a result, monthly reports for the three clinics continued to be prepared by the District Medical Office through traditional manual paper based methods. However, it appeared that these methods were costly as they required the District Medical Officer to travel to different clinics across the district, which also undermined the integrity of the traditional based information system.

Human Resource for Health Research was meant to contribute raw and processed data to support the monitoring, evaluation, and human resource for health planning and budgeting. The principal also enjoyed *narrow decision space* on this intervention area.[7] Decision space was also determined administrative norms and standards, and authority (political legitimacy, technical, financial and organizational support). As a result, it was established that research was undertaken by the Provincial Medical Directorate through the District Medical Office to support policy decision making at the district, provincial and national levels. In essence, the Local Board relied on the visible hand of the District Medical Office for updates and assessments. Private clinics however enjoyed *wide decision space* in research which they undertook as part of the management process though at very limited proportions because of their smaller size.[7] This sector existed parallel to the public sector because of differences in the political and organizational standing between them. Whilst the Local Board played a supervisory role on the local private sector, links with the public sector were weak.

CHAPTER EIGHT
CONCLUSIONS AND RECOMMENDATIONS

8.1 CONCLUSIONS

8.1.1 The decentralization context in the human resource for health reform process

It was concluded that whilst the Epworth Local Board was a municipal authority created through a process of *devolution,* capacity constraints (technical, financial, human resource and material resource) undermined the functioning of the local board towards human resource for health reform. As a result, between 2009 and 2014, the Ministry of Health intervened through its Provincial and District Medical Offices through the process of *deconcentration* towards human resource for health reform. Perhaps it is envisaged that there will be a gradual transition back to devolution once the local board and the local human resource for health system becomes self sustaining. In this context, it was concluded that the human resource for health policy of 2009 to 2014 was implemented through the administrative arms of the Ministry of Health namely the Mashonaland East Provincial Medical Office and the Seke District Medical Office, created through the process of deconcentration. These offices supervised municipal (Local Board) health staff deployed at the two Municipal clinics in Epworth, and healthcare workers employed by the Methodist Mission, working at their clinic in this community. This is because their salaries were paid by the government through the Ministry of Health and Child Care. The Local Board retained ownership of the two Municipal clinics. However, between 2009 and 2014, they also received supervisory authority supervisory assistance directly from the Ministry of Health and Child Care through the Seke District Medical Office and indirectly through a collaborative partnership between the Ministry of Health and an international NGO through which the government intervened by way of a TB and HIV/AIDS Programme.

8.1.2 Human Resource for Health Decision Space and Policy Outcomes

Decision making power on human resource for health planning and financing was undertaken for policy interventions that included demand and supply forecasting, financial budgeting, and the establishment of strategic partnership. It was concluded that there was moderate decision space between the Ministry of Health, Epworth Local Board and Mission in forecasting the demand and supply of healthcare workers. Decision space on human resource planning and financial budgeting was determined by the capacity (financial, technical and

human resource) of actors to make and enforce effective choices. As a resulty, there was functional innovation between the three actors that resulted in a somewhat improved projection of healthcare worker supply towards meeting demand. The local private sector which enjoyed wide decision space on this area contributed somewhat to a limited extent to the local healthcare worker system on this aspect due to a narrow revenue base which accounted for their smaller budgets.

Financial budgeting was characterised by moderate decision space between the Ministry of Health, Epworth Local Board and Mission. Financial capacity was a determinant of decision space between the principal and agent in financial planning for human resources for health. In this moderate decision space, it was concluded that there was also functional innovation through complementary budget structures between actors. Whilst the provision of a budget to help meet top-up allowances by the Mission and Local Board helped complement the payment of salaries by the Ministry of Health towards motivating healthcare workers, it was concluded that the these allowances were not paid to all workers, which had a divisive and demoralising effect on them. It was however also concluded that despite improvements in the financial capacity by the Local Board, available resources failed to meet requirements. This undermined the Local Board's ability to sustain health personnel on its own. Consequently, it had to rely on the Ministry of Health for support towards payment of salaries. However, it was also concluded that the Ministry of Health itself was financially constrained as it failed to meet the 15% minimum expenditure requirement on health set by the Abuja Declaration of 2000. As a result, this undermined its ability to increase human resources in Epworth. Strategic partnerships were also another intervention. It was concluded that decision space on this aspect was narrow. A key determinant of decision space were state political rules of the day that reflected on the ideology and interests that provided strategic direction to the country's foreign policy. As a result, decision space on this aspect was narrow as there was centralised directed action determined by the country's international health relations at a political level.

Decision space towards the production, training and development decision space was determined by administrative norms and standards, and capacity (financial, technical and human resource). Decision making on healthcare worker production, training and development was made on interventions which included capacity strengthening for training

critical healthcare workers, support to healthcare workers for post-basic training, centres of specialization, and induction and exchange programmes. In this regard, it was concluded that decision space on all these policy sub-areas was narrow. Capacity strengthening for training critical healthcare personnel was undertaken by training institutions for which there were none in Epworth. It was also established that Epworth also lacked the technical, financial and human resource capacity to contribute towards this function. It was also concluded that this also accounted for the limited opportunities and support for healthcare workers to pursue post-basic training. As a result, only three healthcare workers received this opportunity which left the majority of the rest demoralised and frustrated. However, it was concluded that on the job training workshops which these healthcare workers attended provided empowerment which enabled them to stay up to date with prevailing trends on different aspects of health service delivery. The situation was however worse for healthcare workers at the private clinics in this community as opportunities and support for post-basic and on the job training were literally non-existent. It was concluded that the need to fill up numbers at local health clinics contributed towards undermining healthcare worker production, training and development in the local human resource for health system.

The conclusion was that there was moderate decision space in which there was functional innovation between the Ministry of Health, Local Board and Mission in the deployment of healthcare workers. This decision space was determined by financial and technical capacity between actors. This resulted in improved deployment between 2009 and 2014. In this context, the Mission and Local Board deployed numbers of healthcare workers whose salaries they could afford, and paid top up allowances towards retaining the majority of healthcare workers deployed by the central government. In this context, it was concluded that the Ministry of Health deployed and paid salaries for 15 healthcare workers at the Mission clinic, 23 at the Municipal clinic specialising on Opportunistic Infections, and 35 at the Municipal polyclinic. To complement this effort, the Local Board deployed 2 Nurses, 2 Nurse Aids, and 4 Security Guards whose salaries it paid on its own. In addition there was a pool of about 30 Community Health Workers. The local private sector also contributed the local private health sector contributed 11 out of the 52 Nurses, and 6 out of the 27 Nurse Aides. It was concluded that the physician to patient ratio of 0, 08: 1000 that was realised from this was a notable improvement because it compared favourably against the ratio of 0, 06: 1000 in the rest of Zimbabwe in 2009. However this improvement is debateable when other factors

are put into consideration. It was also concluded that it also fell short of the World Health Organization estimates that fewer than 2, 3 health workers (physicians, nurses and midwives only) per 1000 would be insufficient to achieve coverage of primary healthcare needs. This was compounded by an unfavorable nurse to patient ratio of 0, 35: 1000 of 2014 that compared less favourably to that of 1, 3: 1000 for the rest of Zimbabwe in 2011. This implied a shortage of Nurses which still persisted in this community by the end of 2014. These shortages manifested by way of a heavy workload of healthcare workers at the two Municipal clinics and one Mission clinic. As a result, healthcare workers were overstretched and demoralised by the large and seemingly overwhelming number of patients. To retain these workers, it was concluded that the government, through the Ministry of Health, intervened through the denomination of all healthcare worker salaries in the United States Dollar, non delayed salary payment each month, provision of support for post basic training, and on the job training.

These incentives to entice were complemented by the payment of top-up allowances by the Mission and Local Board. In addition, the Local Board provided allocated residential stands as a long service benefit to local healthcare workers at the two Municipal clinics. The Mission also made functional innovation by providing free accommodation to some of its staff at its premises. However, it was concluded that despite the fact that their salaries were comparatively higher than those for healthcare workers at the seven private clinics located in the community, and there no being delays in their payment each month, most Nurses indicated that their basic salary was not enough to meet their basic needs. As a result, some had to make do with secondary jobs elsewhere. In addition, it was also concluded that whilst some healthcare workers expressed satisfaction with top-up allowances, some complained that it was not adequate to meet their needs whilst others did not receive the top-up allowance altogether. This created a strong sense of exclusion amongst this category of healthcare workers. Apart from this, it was also concluded that healthcare workers were not happy about the withdrawal of certain benefits that they had received before 2013 and unfulfilled promises. In contrast, it was concluded that private clinics enjoyed wide autonomy in the implementation of retention strategies amongst their healthcare employees. Amongst the strategies used included employment based on kinship ties, airtime allowance, soft loans, free medical treatment for family members, free transport to the workplace, free meals at work, less workload due to fewer patients, medical equipment, and flexible working hours. Despite

these interventions, some of the healthcare workers were not satisfied with low salaries and delays in salary payment. It was also concluded that their salaries were comparatively much lower than for those at the Municipal and Mission clinics, and that their retention benefits were different and comparatively less favourable. However, an overall assessment on the levels of satisfaction amongst healthcare workers employed at the clinics in this community pointed towards the lack of satisfaction which pointed to the fact that healthcare workers were most likely not to be retained.

It was concluded that there was moderate decision space towards performance management for healthcare workers at the two Municipal clinics and one Mission clinic. However from the inquiry at the Provincial Medical Office, it was concluded that the financial incapacity, and the design of the Results based Performance Management System undermined implementation. In practice, whilst performance management was undertaken by Provincial Medical Directorate, District Medical Office and Community Health Officer, it was overshadowed by staff shortages and the visibly overwhelming workload which had an overstretching effect for staff in a high pressure environment. Private clinics enjoyed wide decision space on performance management, which took place through mutual discussion and advice between the facility manager/ owner and the healthcare worker if need be.

There was narrow decision space on health labour relations as everything was defined by the law of the land for all healthcare workers in this peri-urban community. Rules and regulations were a determinant of decision space. The rights of the employer and employees were provided for in legislation which included the Constitution of Zimbabwe, Health Service Act (Chapter 15:16 No. 28/2004), Labour Act (Chapter 28:01), Public Health Act (Chapter 15:09), Medical Services Act (Chapter 15:13), and Health Professions Act (Chapter 27:19). Whilst the centralised nature of health labour relations undermined the extent to which healthcare workers could bargain for more favorable working conditions, it was concluded that the retention strategies mentioned above, and the difficult socio-economic situation during this period undermined the relevance of healthcare workers engaging on this matter, especially also considering that better alterative employment opportunities elsewhere were literally non-existent.

Health and safety welfare were also another functional area. In this, decision space on the health welfare of human resources for health was wide for all healthcare workers at the clinics who were free join a medical aid scheme of their own. Decision space on this area was determined by analysis of the capacity (financial) of actors to enforce choices towards meeting the health welfare of personnel. However, it was concluded that the absence of a subsided medical aid scheme made healthcare workers reluctant to join medical aid schemes because of the effect that it would have on their low salaries. To counter this, clinics in the community innovated by offering free medical treatment for their healthcare workers and their families. On safety welfare, the decision space was narrow. There were clinical procedures and standards set by the Ministry of Health and Child Care, in line with the World Health Organization Requirements which outlined the protocol to be followed to protect healthcare workers. The most prominent of these were the Prophylaxis Guidelines which were helping protect healthcare workers from accidental contraction of HIV/AIDS whilst performing their duties. However, it was concluded that narrow decision space undermined enforcement particularly amongst non-medical cadres who depended on knowledge transfer from medical personnel who would have received on the job training on them. In turn, this undermined somewhat undermined healthcare worker safety.

It was concluded that decision space on Human Resource for Health Information and Research this area was narrow. Decision space was based on administrative norms and standards set by the Ministry of Health in line with post 2009 Human Resource for Health Policy towards health system reform. However, a lack of technical and financial resources undermined the implementation of the Human Resource for Health Information System and effort towards the establishment of the National Health Workforce Observatory. As a result, monthly reports on the staff establishment were provided by the three clinics to the District Medical Office through manual paper based methods. On the other hand, it was also concluded that research was meant to contribute raw and processed data to support the monitoring, evaluation, and human resource for health planning and budgeting. The principal enjoyed *narrow decision space* on this intervention area because of the need to enforce implementation towards reform, keep track of data on health personnel at the municipal and mission clinics, almost all of whom were on the civil service payroll, and for accountability purposes to the Ministry of Health. For this purpose, the principal enjoyed political legitimacy, technical, financial and organizational support from the Ministry of Health.

Decision space was based on the authority by the principal. As a result, research was undertaken by the Provincial Medical Directorate through the District Medical Office to support policy decision making at the district, provincial and national levels. However, links with the private sector were also weak on this result area.

8.1.3 Decision Space Mapping Analysis, Human Resource for Health Reform and the Health System Reform Agenda

It was concluded that literature on the health system reform agenda does not provide a detailed narrative towards human resource for health reform. This is because health sector reform often focuses on aspects such as changes in financing or organisational structure, but neglecting a key resource, human resources for health. Also, whilst Decision Space Mapping Analysis has been used towards the health system reform agenda, focus was on aspects which include finance, service organization, human resources, access rules and governance rules.[1] However, literature on Decision Space Mapping Analysis does not provide a detailed narrative on the decentralization of the human resource function beyond salaries, contracts and civil service. Consequently, this has resulted in an inappropriate fit between the functioning of human resources for health and the health system reform process through, for instance, inappropriately skilled staff for new tasks, poorly motivated staff, or even serious opposition to the reforms. The need for human resource for health reform has also recently emerged on the global agenda as reflected for example through the Declaration of Alma Atta, Quagadougou Declaration, Africa Health Strategy on Human Resources for Health, SADC Protocol on Health, 2006 World Health Report and the Kampala Declaration and Agenda for Global Action. Against this background, a Human Resource for Health Policy Decision Space Mapping Analysis Conceptual Tool consisting of six policy result areas was developed. Using the Decision Space Approach, it was then used to analyse how the Zimbabwean Human Resource for Health Policy of 2009 to 2014 impacted the Local Human Resource for Health System of Epworth, Harare. It consisted six result areas that included Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Human Resource for Health Information and Research; Labour Relations; and Health and Safety. In this, the aim was to determine three issues in policy implementation towards reform. Firstly, the amount of decision space transferred from the principal (Ministry of Health and other policy community actors at the national level) to the agent (local government institutions at the periphery).

Secondly, the decisions local officials made with their decision space around these six result areas, and thirdly outcomes (effect) of these choices on the performance of the local human resource for health system in Epworth, Zimbabwe.[1]

8.1.4 Overall conclusion on policy impact

It was also concluded that intervention by the principal between 2009 and 2014 was both necessary and inevitable because the agent lacked financial, technical and human resource capacity to make the local healthcare worker system functional. Compounding this was the context associated with peri-urbanization, characterised by unfavourable determinants of health which included semi-formal settlement, impoverishment, immigration, narrow revenue base, lack of amenities and a high disease burden. The decentralization of human resource for health policy helped revitalise the local human resource for health system in Epworth. However, the overall conclusion is that the decision effort made fell short of requirements and standards, a scenario that has unfavourable implications towards the attainment of the 2030 Sustainable Development Goals and beyond.

8.2 RECOMMENDATIONS

8.2.1 Decision space action towards better human resource for health reform outcomes

8.2.1.1 Human resource for health planning and budgeting decision space

In this result area, it was concluded that there was *moderate decision space* for both health personnel demand and supply, and financial budgeting for the two Municipal clinics and one Mission clinic.[7] This emanated from capacity constraints on the part of the local board and mission. Moderate decision space enabled actors, namely the local board, mission, and health ministry to complement each other's capacity towards reform in this aspect of human resource for health policy. It is therefore recommenced that moderate decision space be reinforced towards sustained complementary capacity building (financially, technically and human resource) towards desired objectives. Further, it is also recommenced that the local board and mission engage in more functional innovation towards self-sustainability in the capacity to enforce decisions in human resource planning and financial budgeting to shift the burden off the Ministry of Health. Being a devolved municipality, the local board has authority to collect revenue from the local community. It is therefore recommended that the local board expands its revenue base. This can be attained through formalization of semi-formal settlement by resettling locals into structured residential stands from where revenue may then be collected. One of the best ways proposed is the establishment of formal housing units into which some locals in semi-formal dwellings may gradually be transferred, whilst those remaining may have their dwellings formalised somehow. Whilst this proposal may require financial resources, the solution may be to pursue the idea through government and donor assistance, and/or twinning arrangements with more established cities of the world for technical and financial assistance.In addition, formal business enterprises may be set-up at different locations in the new formal residential structures, from where more revenue may be collected, towards financing human resource for health reform. After this, there may then be consultative enagement with the Ministry of Health through Provincial and District Medical Offices towards aligning local innovations with the broader human resource for health policy objectives, but with the local board enjoying wide decision space. However, these ideals appear a fallacy in the context that prevailed at the end of 2014, a context characterised by capacity constraints to engage in functional innovation towards the payment of top-up allowances to all healthcare workers and the provision of material resources to support healthcare workers by the mission and the local board. It is therefore recommended that moderate decision space, in which the Ministry of Health, local board and mission engage in

complementary effort be reinforced to overcome capacity constraints in expenditure on healthcare workers into the foreseeable future towards desired reform outcomes in this result area.

8.2.1.2 Strategic partnerships decision space

It was concluded that decision space on this aspect was determined by the state political rules of the day that reflected on the ideology and interests that provided strategic direction to the country's foreign policy. As a result, decision space on this aspect was narrow as there was centralised directed action determined by the country's international health relations at a political level.[7] Further, it was also concluded that this had resulted in a programme specific partnership on HIV/AIDS and TB was entered into with an international Non Governmental Organization. Given the financial and technical capacity constraints on the part of the mission, local board, and Ministry of Health, it is recommended that engagement with the strategic partner be reinforced until such a time that constraints have been overcome and desired human resource for health reform outcomes have been realised in Epworth peri-urban community. It may be difficult for the principal to relinguish more decision space to the agent on this aspect as there may be a clash over political interets priorities on this aspect In addition, it is also recommended that the Ministry of Health engages more international strategic partners to help spread the burden in areas other than HIV/AIDS, and TB towards human resource for health reform in Epworth peri-urban community. Amongst these areas may include the payment of top-up allowances, provision of material and technical assistance, deployment and retention of more healthcare workers.

8.2.1.3 Production, training and development decision space

From this study, it was concluded that there was narrow decision space on this result area.[7] This space was based on administrative norms and standards, and actor capacity (financial, technical and human resource) on this area. It is therefore recommended that capacity strengthening for the training of critical healthcare workers undertaken by training institutions across the country through the relevant Ministries, and the establishment of centres of specialization be reinforced towards the production, training and development of healthcare workers for Epworth. In addition, it is also recommended that there is need for the principal to innovate more functionally towards the provision of support for post-basic training to more healthcare workers through encouragement, facilitated enrolment, paid study

leave, and tuition fee waiver for Diploma or Higher National Diploma courses. However, it must also be noted that this can only happen in Epworth once more healthcare workers have ben deployed in Epworth to avoid shifting the burden of work on human resources for health who remain behind whilst others are away on study leave. It is also recommended that there is need to build financial capacity of the local board towards allocating more decision space towards support for healthcare workers to enrol for post basic training. A key strategy already proposed is broadening the financial resource base of the local board, mission and local private sector to enable them to make more effective choices and execute them towards the human resource for health reform agenda.

8.2.1.4 Decision space towards the deployment of adequate staff

It was concluded that moderate decision space contributed towards improvements in the deployment of healthcare workers in the local human resource for health system.[7] Despite this however, it was also concluded that the effort made fell short of requirements and standards which manifested by way of a heavy workload at the two Municipal clinics and Mission clinic. Therefore, there is need for more functional innovation by actors towards a more favorable physician to patient, and nurse to patient ratios. One of the proposed mechanisms to help overcome the shortages may also include the enhancement of the role of the family in health as this helps contain the outbreak of diseases through the promotion of healthy lifestyles and living practices. In addition, it is also recommended that the Local Board formalizes semi-formal settlement to expand its revenue base towards more healthcare worker funding to help improve the number of healthcare workers deployed in Epworth.

Further, it was concluded that moderate decision space resulted in the deployment of community health workers which had the subsequent effect of bringing the most satisfaction amongst medical and non-medical healthcare workers. It is therefore recommended that complementary effort between the Ministry of Health, Local Board and International NGO be reinforced and sustained through continued functional innovation by actors. Such innovation entails more reinforcement of the integration of community health workers into the mainstream of the local human resource for health system. An idea on this may be borrowed from literature on interventions in the United States. It proposes strengthening of the role of Community Health Workers (CHWs) to enable them to become collaborative leaders in dramatically changing health care from sickness care to systems that provide comprehensive

care for individuals and families and supports community wellness. It is recommended that this entails drawing on the full spectrum of CHWs' roles so that they can make optimal contributions to health systems and the building of community capacity for health and wellness. Further, it is also recommended that CHWs be integrated into community health teams as part of medical homes and that evaluation frameworks be improved to better measure community wellness and system change.[67] Other recommendations include the recruitment and deployment of an adequate number of personnel to bring up numbers to at least five people for each of the wards. In addition, it is recommended that personnel be provided with equipment which may include a first-aid kit and bicycles, and also regular training. Apart from this is a living allowance so as to help retain the volunteers and for them sustain themselves. In Ghana, the recruitment, training, equipment and deployment of adequate numbers of Community Health Volunteers facilitated the implementation of the Community Health Compounds Initiative. As a result, health coverage reached out to previously underserved areas which also resulted in improvements in health interventions which included health communication, identification of unregistered pregnancies, basic home based care, patient follow-ups, and monitoring and reporting the local health situation.[68,69]

Apart from this, it is recommended that the Peers Educators Initiative also be reinforced through integrative capacity building, to provide them with more training on the non-medical aspects of service provision such filling, basic counselling, and cleaning of the premises to help ease the workload particularly on medical personnel. It is also recommended that they be provided with protective clothing to protect them from contracting diseases whilst working at the clinic. In addition, uniforms will also help overcome stigma that they experienced whist working at the clinics in the community. Functional innovation between actors is also recommended in the provision of retention incentives to medical and non-medical healthcare workers.

8.2.1.5 Retention decision space

There is need to sustain moderate decision space in the provision of retention between the Ministry of Health, Local Board, and Mission in Epworth. In this regard, it is recommended that all parties play their part to the full towards healthcare worker retention.[7] There is need to reinforce functional innovation to ensure that the payment of top-up allowances is made to all healthcare workers in a manner that is non-exclusionary to overcome the divisive and

demoralising effect noted amongst healthcare workers at the two Municipal clinics and Mission clinics. This will also help instil a sense of belonging and satisfaction. Functional innovation might entail more collaboration and engagement of the donor community or programme specific NGO intervention that brings in more financial resources to benefit healthcare workers. Apart from this, decision effort must be sustained towards the provision of other retention benefits which include free residential stands, free accommodation, and sundries to help support work effort. There is need also to reinstate the provision of withdrawn benefits such as uniforms, a jersey, soap for washing, school fees for their children and free lunch at the workplace. In addition, there is need to provide either a transport allowance or transport to and from the Central Business District for healthcare workers at the two Municipal clinics, and Mission clinic to also help overcome challenges in that area. The proposal of either an increment of the transport allowance to levels that correspond to cost or a staff bus to ferry staff members to and from a central pickup point in Harare's Central Business District each morning and evenings may provide a channel towards meeting expectations. For the private sector however, the reinforcement and sustenance of the strategies implemented between 2009 and 2014 is recommended.

8.2.1.6 Health and safety welfare decision space

Decision space on health welfare was wide.[7] However, low salaries made healthcare workers reluctant to join medical aid schemes on their own. Considering the risk nature of their employment, particularly at the Opportunistic Infections Clinic, it is therefore recommended that the Local Board and Mission comes up with a local health insurance scheme to help healthcare workers access care in higher level referral institutions in the event that such treatment is not available locally. Apart from this, it is also recommended that training on safety protocol be provided to all healthcare workers regardless of whether they are medical or non-medical staff to help protect them from accidental infection and contracting of diseases that are now avoidable.

8.2.1.7 Human Resource Information and Research decision space

It was concluded that the implementation of choices made in the context of narrow decision space in this area was undermined by the lack of technical and financial resources. As a result, desired outcomes towards the implementation of the Human Resource for Health Information System and establishment of the Health Workforce Observatory were not

realised. At the same time, the agent (local board, mission and private sector) was technically and financially incapacitated to implement this intervention on their own. This undermined prospects of a transition from narrow to moderate decision space if any. The establishment of a human resource for health information system appeared appropriately positioned at the principal level for better coordination of data from other municipalities throughout the country towards informing decision making at the highest level of policy making. This literally meant that narrow decision space decision space enjoyed by the principal was appropriate. However, it is recommended that there is need to build technical, financial and human resources capacity towards the establishment of the healthcare worker observatory, and the conduct of research. Research and a comprehensive Human Resource for Health Information System (HRHIS) help inform Human Resource for Health Planning and other subsequent aspects of the Human Resource for Health Policy. Therefore functional innovation towards buiding capacity to implement interventions in these areas is an absolute necessity towards the establishment of a human resource for health information system and research by the principal.

8.2.2 Further research towards Human Resource for Health Reform

It was concluded that literature of the twenty first century did not provide a detailed narrative on the decentralization of the human resource policy function towards the human resource for health policy reform agenda.[7] Further, from a review of literature on this subject area, it was also concluded that human resource for health reform in itself has been overlooked in health sector appraisal. Consequently, this may result in an inappropriate fit between the human resource for health policy function and the health system, and undermine the objectives of health system appraisal as was experienced in Latin America.[42] Therefore, it is recommended that there is need to consider human resource for health reform as the mainstream through which health system appraisal may be undertaken. To this end, it is recommended that studies on human resource for health reform focus on the core of the health personnel policy function. This implies the need for a more detailed narrative of the human resource for health in Decision Space Mapping Analysis beyond salaries, contracts and civil service.[7] This need has also recently emerged on the global agenda as reflected for example through the Declaration of Alma Atta, Quagadougou Declaration, Africa Health Strategy on Human Resources for Health, SADC Protocol on Health, 2006 World Health Report and the Kampala Declaration and Agenda for Global Action. It is therefore recommended that a more

detailed narrative towards human resource for health reform may include policy functions drawn from literature which include human resource planning; production, training and development; deployment, retention, utilization and management; human resource for health information and research; labour relations; and health and safety welfare.

8.2.2.1 The Human Resource for Health Decision Space Mapping Analysis Conceptual Tool

It was concluded that whilst Decision Space Mapping Analysis has been used towards the health system reform agenda, the focus on human resources for health did not provide a detailed narrative beyond salaries, civil service and contracts. Against this background, a Human Resource for Health Policy Decision Space Mapping Analysis Conceptual Tool outlined in Table 19 below, is recommended for use withj adaptive modifications towards human resource for health reform. In this, analysis will focus on six policy result areas that include: Human Resources Planning and Financing; Production, Training and Development; Deployment, Retention, Utilization and Management; Human Resource for Health Information and Research; Labour Relations; and Health and Safety.

Table 19: The Human Resource for Health Decision Space Mapping Analysis Conceptual Tool

RESULT AREAS	RANGE OF CHOICE			IMPACT [xvi]
	Narrow	Moderate	Wide	
Human Resource Planning and Financing				
• Demand and Supply Forecasting				
• HRH Financial Budgeting				
• HRH Strategic Partnerships				
Production, Training and Development				
• Capacity building for training critical HRH				
• Support for further training				
• Centres of specialization				
• Induction and exchange programmes				
Deployment, Retention, Utilization and Management				
• Deployment				
• Retention and motivation				
• Performance management and utilization				
Health Labour Relations				
• Rights framework				
Health and Safety				
• Health welfare				
• Safety and protection				
Human Resource Information and Research				
• HRH Information System				
• HRH Research				

Idea adapted from Bossert.[1]

Using this conceptual tool, it was established that the Ministry of Health intervened and retained narrow decision space in health personnel production, training, development; strategic partnerships, labour relations, safety, protection, and information and research for the Local Board and Mission. The Local Board and Mission also enjoyed moderate decision

[xvi] Impact is the performance (policy outcomes and impact) which occurs as a result of decision space and innovation by actors in a health system.

space in demand and supply forecasting, deployment, retention, financial budgeting and performance management. The local private sector enjoyed wide decision space on all policy functions. Conclusively, intervention and decision space by the principal (Ministry of Health) towards reform was necessary because of the unfavorable local context and lack of capacity by the agent (Local Board). In this context, it is also recommended that the Decision Space Approach be used to determine the amount of decision space transferred from the principal (Ministry of Health and other policy community actors at the national level) to the agent (local government institutions at the periphery), the decisions local officials made with their decision space around these six result areas, and outcomes in terms of the effect that these decisions had on the performance of the local human resource for health systems. Further, it is recommended that this application may be adopted with adaptive modifications in similar studies at a local level globally towards the health system reform agenda of the twenty-first century and beyond.

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ANNEXURES

KEY INFORMANT GUIDE FOR NATIONAL AND REGIONAL POLICY MAKERS: [DIRECTOR OF HUMAN RESOURCE FOR HEALTH POLICY FOR THE MINISTRY OF HEALTH AND CHILD CARE] [DIRECTOR OF HUMAN RESOURCE FOR HEALTH FOR THE HEALTH SERVICES BOARD] [PROVINCIAL MEDICAL OFFICER] [DICTRICT MEDICAL OFFICER] [ZIMBABWE ASSOCIATION OF CHURCH HOSPITALS] [HEALTH PROFESSIONS ASSOCIATION] [ACADEMIC COMMUNITY] [OTHER MINISTRIES AND ASSOCIATIONS]

INTRODUCTION

Good morning/afternoon. My name is_____ and I am a student from the University of Pretoria. I am currently undertaking an academic survey as part of my PhD studies to examine the implementation of the Human Resources for Health Strategic Plan 2010-2014, and its impact on your ward. The information you provide will be treated in confidence and for this academic purpose only.

Our discussion will focus on:

- your decision role in the implementation of the aforementioned intervention; and
- impact on your country/ province/district.

We will discuss the role of your organization in the implementation of this policy intervention health personnel at:

-Government;
-Council (Local Government);
-Faith based (voluntary); and
-Private for profit health establishments.

May you please kindly note that specific reference in our discussion will be made to Epworth.

May you please note that our discussion may take about an hour (60 minutes). I also kindly ask for your permission to record our discussion so that I may be able to capture some things later on that I might miss during the interview.

Researcher Name: _____
Date: _____ Start time: _____ Finish time: _____

SECTION A

I am going to start by asking you a few questions about your organization.

Organizational role and function
1a. What is the role played by your organization in the implementation of the **Human Resource for Health policy** in Zimbabwe? b. What was the main role played by your organization in the implementation of the **Human Resources for Health Strategic Plan 2010-2014**? (Probe on the implementation structures; and role of the implementation actors) c. Who were the main decision actors **at this level** in the implementation of this **Human**

Resources for Health Strategic Plan 2010-2014? [Probe for government *(ministries),* local government *(council)*, private for profit, and voluntary sector *(Faith based organization, NGOs, informal)*]

Now let us talk about the Human Resource for Health situation before 2010.

Human Resources for Health Situation Analysis
2. What were the main human resources for health challenges before 2010 in this **country/ province/district**? [With particular reference to Epworth, probe on the availability, accessibility, acceptability and affordability of services by HRH]

Let us now proceed to discuss the implementation of the Human Resources for Health Strategic Plan 2010-2014.

May you note that our discussion is going to focus on the following key four major result areas of this intervention:
Result area 1- Human Resources Planning and Financing;
Result area 2- Production, Training and Development of Human Resources for Health;
Result area 3- Deployment, Retention, Utilization and Management; and
Result area 4- Human Resource Information and Research.

3. Explain the decision role played by your organization on the following in this province:

a. Human Resource Planning and Financing	
	Probes
Determination of the of HRH policy operational frameworks? ***For example*** Stakeholder consensus meetings on the HRH Strategic Plan; Engagement of UN and partners to finance training of HW; Development of intermediate and costed annual operating work plans; and Progress review meetings.	Determination of the HRH policy operational frameworks in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Determination of Policies and Strategies on the attraction and retention of health personnel, and improvement of working conditions?	Determination of attraction and retention operational frameworks for this country/ province/district for:

For example Review of attraction and retention policies; Lobby stakeholders on stands, houses, vehicles and study loans; Benchmark salaries to SADC levels; and Lobby parliament for more funding.	-government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Management of the impact of HIV and AIDS on HRH in the health service? ***For example*** Development and implementation of an HIV/AIDS workplace policy; and Development and implementation of a biosafety and bio security policy for HRH.	Determination of the management frameworks for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Establishment of the platform for strategic partnerships on HRH with national, regional, continental, and international groupings ***For example*** Platform/technical working groups for HRH; and Collaborative projects for training, recruitment and compensation with other international and regional organizations.	Establishment of the platform in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs and outcomes.
Review framework for health worker skills mix for the country/ province/ district/ community based on prevailing needs within the region?	Review of frameworks in this country/ province/district for: -government health workers*;*

For example Train Managers and HR Staff in workforce planning; and Review skills mix for planning purposes.	-local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Updating and use of the HRH Information system to assist planning and to rationalise all HRH management functions? ***For example*** Baseline study to determine the use of ICT for HRH; Development of a framework for use of ICT in HRH; and Development of a national HRH database.	Updating of the HRHIS in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Establishment of the HRH Observatory? ***For example*** Appointment of a working group.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.

b. Production, Training and Development of Human Resources for Health	
	Probes
Strengthening capacity for training of critical human resources for health? ***For example*** Conduct skills audit; Review of staffing norms for the health sector and training institutions; Development of a 10 year HRH master plan; Development/review, implementation of training standards and monitor the minimum standards for training schools; Training of the appropriate categories of HWs to match the national HRH need; and Solicit funding for training institutions.	Strengthening of capacity in this country/ province/district for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Increase production output of health workers with critical post basic and postgraduate qualifications? ***For example*** Training, and to fund training, of: Lecturers and tutors; Midwives; Clinical officers; Nurses; and Doctors.	Role in this country/ province/district for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Support of health workers to undertake Diploma/Higher National Diploma programmes?	Supporting role in this country/ province/district for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this country/ province/district?

	Policy outputs; Outcomes; and Impacts.
Identification, development and establishment of centres of specialization? ***For example*** Establishment of a baseline on existing and potential centres of specialization; and Identification of staff categories to be trained in the first five year period.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Development and implementation of national frameworks and mechanisms for exchange programmes and attachments? ***For example*** Establishment of a baseline on existing and potential centres of specialization; and Identification of staff categories to be trained in the first five year period.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Development and implementation of induction programmes ***For example*** Development of an induction manual for all new staff.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this

	country/ province/district? Policy outputs; Outcomes; and Impacts.
Training of all managers in leadership and management skills ***For example*** Training on: -health service regulations; -management skills; -computer skills; -succession planning; -short courses, seminars and workshops abroad; -M&E; and -HRHIS.	Role in this country/ province/district for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.

c. Deployment, Retention, Utilization and Management	
	Probes
Ensuring equitable recruitment/employment of staff? ***For example*** -decentralization of recruitment functions for selected levels; and -review of recruitment guidelines of qualified foreign health personnel.	Role in this country/ province/district for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Ensuring equitable deployment of staff? ***For example***	Role in this country/ province/district for:

-Review of deployment criteria for graduates.	-government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Ensuring equitable retention/motivation incentives (intrinsic and extrinsic incentives) for staff? ***For example*** Provision of: -adequate accommodation; -staff loans for housing and transport; -provision of competitive salaries pegged to regional scales; -housing allowance for staff; -transport allowance; -adequate clothing; -tax subsidies/exemption on vehicles for eligible staff; -subsidised medical costs; -honour conditions of service; -rest; and -tax exemption, allowances and incentives.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Ensuring equitable management and utilization of staff ***For example*** -implementation of the results based performance management system; and -expedite disciplinary procedures.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.

d. Human Resource Information and Research	
	Probes
Development and strengthening of the HRHIS to assist planning and to rationalise all HRH management functions. ***For example*** -Development of a national framework for the HRHIS including a National Observatory; -Establishment of a Zimbabwean Health Workforce Observatory; -Development and implementation of a national HRHIS; and -Assessment of the current Human Resource System in the country.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.
Provide data and information for evidence based policy formulation, planning and management of HRH. ***For example*** -Conduct of a desk review of current HR studies; -Development of a National HRH research agenda; -Mobilization of resources for HRH Research; and -Contribution to articles for HSB, Ministry and regional organizational websites.	Role in this country/ province/district for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this country/ province/district? Policy outputs; Outcomes; and Impacts.

END AND THANK **END TIME: _____**

KEY INFORMANT GUIDE FOR LOCAL POLICY MAKERS
[EPWORTH LOCAL BOARD HUMAN RESOURCE FOR HEALTH POLICY MAKER ; COMMUNITY HEALTH OFFICER]

INTRODUCTION

Good morning/afternoon. My name is_____ and I am a student from the University of Pretoria. I am currently undertaking an academic survey as part of my PhD studies to examine the implementation of the Human Resources for Health Strategic Plan 2010-2014, and its impact on your ward. The information you provide will be treated in confidence and for this academic purpose only.

Our discussion will focus on:
- your decision role in the implementation of the aforementioned intervention; and
- impact on your community/ ward.

May you please note that our discussion may take about an hour (60 minutes). I also kindly ask for your permission to record our discussion so that l may be able to capture some things later on that I might miss during the interview.

If applicable, record ward number here_____

To start with, let us talk about your Community/ Ward's public health situation analysis before and after 2010.

Community Public Health Situation Analysis	**Probes**
1. What were the main community health challenges before 2010?	-Causes and drivers of the challenges; -Health system; -Infrastructure and community set up; and -Communicable and non communicable diseases.
2. What were the main community health challenges between 2010 and 2014?	-Causes and drivers of the challenges; -Health system; -Infrastructure and community set up; and -Communicable and non communicable diseases.
3 Who were the main health service providers in this community/ ward before 2010.	-Government facilities; -Local municipality; -Private for profit; -Non Government Organizations including missions; -Community Health

	Workers; and -The informal.
4. Who were the main health service providers in this community/ ward between 2010 and 2014?	-Government facilities; -Local municipality; -Private for profit; -Non Government Organizations including missions; -Community Health Workers; and -The informal.
5. May you please explain the relationship between the Local Human Resource for Health Policy Decision System Structured (/ or Local Board) and the following actors: -Seke District Medical Office; -Mashonaland East Provincial Medical Directorate; -Ministry of Health and Child Care; and -Ministry of Local Government/ or City of Harare	-What are the roles of decision actors -How do they relate to the district, provincial, and national levels?

Let us now proceed to discuss about the implementation of the Human Resources for Health Policy interventions in this community/ ward.

Our discussion will focus on your decision role and outcomes associated with the policy instruments of the Human Resource for Health Strategic Plan implemented between 2010 and 2014.

Specific focus will be on the following:
Result area 1- Human Resources Planning and Financing;
Result area 2- Production, Training and Development of Human Resources for Health;
Result area 3- Deployment, Retention, Utilization and Management; and
Result area 4- Human Resource Information and Research.

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6. Explain the decision role played by your organization on the following in this province/ district/ community:

a. Human Resource Planning and Financing	
	Probes
Determination of the of HRH policy operational frameworks? ***For example*** Stakeholder consensus meetings on the HRH Strategic Plan; Engagement of UN and partners to finance training of	Determination of the HRH policy operational frameworks in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers;

HW; Development of intermediate and costed annual operating work plans; and Progress review meetings.	-voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Determination of Policies and Strategies on the attraction and retention of health personnel, and improvement of working conditions? ***For example*** Review of attraction and retention policies; Lobby stakeholders on stands, houses, vehicles and study loans; Benchmark salaries to SADC levels; and Lobby parliament for more funding.	Determination of attraction and retention operational frameworks for this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Management of the impact of HIV and AIDS on HRH in the health service? ***For example*** Development and implementation of an HIV/AIDS workplace policy; and Development and implementation of a biosafety and bio security policy for HRH.	Determination of the management frameworks for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Establishment of the platform for strategic partnerships on HRH with national, regional, continental, and international groupings ***For example*** Platform/technical working groups for HRH; and Collaborative projects for training, recruitment and compensation with other international and regional organizations.	Establishment of the platform in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.

Review framework for health worker skills mix for the country/ province/ district/ community based on prevailing needs within the region? ***For example*** Train Managers and HR Staff in workforce planning; and Review skills mix for planning purposes.	Review of frameworks in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Updating and use of the HRH Information system to assist planning and to rationalise all HRH management functions? ***For example*** Baseline study to determine the use of ICT for HRH; Development of a framework for use of ICT in HRH; and Development of a national HRH database.	Updating of the HRHIS in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Establishment of the HRH Observatory? ***For example*** Appointment of a working group.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.

b. Production, Training and Development of Human Resources for Health	
	Probes
Strengthening capacity for training of critical human resources for health? ***For example***	Strengthening of capacity in this community for: -local government *(council/*

Conduct skills audit; Review of staffing norms for the health sector and training institutions; Development of a 10 year HRH master plan; Development/review, implementation of training standards and monitor the minimum standards for training schools; Training of the appropriate categories of HWs to match the national HRH need; and Solicit funding for training institutions.	*municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Increase production output of health workers with critical post basic and postgraduate qualifications? ***For example*** Training, and to fund training, of: Lecturers and tutors; Midwives; Clinical officers; Nurses; and Doctors.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Support of health workers to undertake Diploma/Higher National Diploma programmes?	Supporting role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Identification, development and establishment of centres of specialization? ***For example*** Establishment of a baseline on existing and potential centres of specialization; and Identification of staff categories to be trained in the first five year period.	Role in this community for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs;

	Outcomes; and Impacts.
Development and implementation of national frameworks and mechanisms for exchange programmes and attachments? ***For example*** Establishment of a baseline on existing and potential centres of specialization; and Identification of staff categories to be trained in the first five year period.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Development and implementation of induction programmes ***For example*** Development of an induction manual for all new staff.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Training of all managers in leadership and management skills ***For example*** Training on: -health service regulations; -management skills; -computer skills; -succession planning; -short courses, seminars and workshops abroad; -M&E; and -HRHIS.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.

c. Deployment, Retention, Utilization and Management	
	Probes
Ensuring equitable recruitment/employment of staff? ***For example***	Role in this community: -local government *(council/*

-decentralization of recruitment functions for selected levels; and -review of recruitment guidelines of qualified foreign health personnel.	*municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Ensuring equitable deployment of staff? ***For example*** -Review of deployment criteria for graduates.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Ensuring equitable retention/motivation incentives (intrinsic and extrinsic incentives) for staff? ***For example*** Provision of: -adequate accommodation; -staff loans for housing and transport; -provision of competitive salaries pegged to regional scales; -housing allowance for staff; -transport allowance; -adequate clothing; -tax subsidies/exemption on vehicles for eligible staff; -subsidised medical costs; -honour conditions of service; -rest; and -tax exemption, allowances and incentives.	Role in this community: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Ensuring equitable management and utilization of staff ***For example*** -implementation of the results based performance management system; and -expedite disciplinary procedures.	Role in this community: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers?

	Policy outputs; and Outcomes.
d. Human Resource Information and Research	
	Probes
Development and strengthening of the HRHIS to assist planning and to rationalise all HRH management functions. ***For example*** -Development of a national framework for the HRHIS including a National Observatory; -Establishment of a Zimbabwean Health Workforce Observatory; -Development and implementation of a national HRHIS; and -Assessment of the current Human Resource System in the country.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.
Provide data and information for evidence based policy formulation, planning and management of HRH. ***For example*** -Conduct of a desk review of current HR studies; -Development of a National HRH research agenda; -Mobilization of resources for HRH Research; and -Contribution to articles for HSB, Ministry and regional organizational websites.	Role in this community for: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers? Policy outputs; Outcomes; and Impacts.

Finally, we are now comparing the HRH situation:
-before 2010; and
-the situation between 2010-2014.

7. HEALTH PERSONNEL SERVICE OUTCOMES

AVAILABILITY	**Probes**
How was the availability of health personnel in this community 2009?	Adequacy of cadres: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians,

	Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
How was the availability of health personnel in this community between 2009 and 2014? Were there positive/negative changes? Improved availabiliy/no improvement?	Adequacy of cadres: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
What were the drivers for these changes on availability between 2009 and 2014?	Probe on decisions made by -who; -when; -how; and -for which cadres
What are your recommendations on availability?	Adequacy of cadres: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists,

	Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]

AFFORDABILITY	**Probes**
How was the affordability of services by health personnel in this community before 2009?	Affordability of services by: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
How was the affordability of services by health personnel in this community between 2009 and 2014? Did they become more affordable/ less affordable?	Affordability of services by: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians];

	and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
What were the drivers for these changes on affordability between 2009 and 2014?	Probe on decisions made by -who; -when; -how; and -for which cadres
What are your recommendations on affordability of services?	Affordability of services by: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]

THANK AND END

IN-DEPTH INTERVIEW GUIDE FOR HUMAN RESOURCE FOR HEALTH MANAGERS [SISTER IN CHARGE; DOCTOR IN CHARGE OF STAFF AT THE FACILITY]

INTRODUCTION

Good morning/afternoon. My name is_____ and I am a student from the University of Pretoria. I am currently undertaking an academic survey as part of my PhD studies to examine the implementation of the Human Resources for Health Strategic Plan 2010-2014, and its impact on your ward. The information you provide will be treated in confidence and for this academic purpose only.

Our discussion will focus on:

- your decision role in the implementation of the aforementioned intervention; and
- impact on health personnel in your facility.

May you please note that our discussion may take about an 30 minutes. I also kindly ask for your permission to record our discussion so that l may be able to capture some things later on that I might miss during the interview.

Researcher Name: _____
Date: _____ Start time: _____ Finish time: _____

To start with, let us talk about your Community/ Ward's public health situation analysis before and after 2010.

Community Public Health Situation Analysis	**Probes**
1. What were the main health challenges in your catchment area in this community before 2009?	-Causes and drivers of the challenges; -Health system; -Infrastructure and community set up; and -Communicable and non communicable diseases.
2. What were the main community health challenges between 2009 and 2014?	-Did the health challenges change or remained the same? -Causes and drivers of the challenges; -Health system; -Infrastructure and community set up; and -Communicable and non communicable diseases.
3. How does your Human Resource Policy decision role relate to the following:	-Epworth Local Board; -Seke District Medical Office; -Mashonaland East

	Provincial Medical Directorate; -Ministry of Health and Child Care; and -Ministry of Local Government/ or City of Harare.

HEALTHWORKER SITUATIONAL ANALYSIS

4	How does the healthcare worker situation at your facility before 2009 compare with that of the period between 2009 and 2014?	Probe on: -healthworker challenges before 2009 -availability, accessibility; -motivation and morale; -braindrain levels.	

Let us now proceed to discuss about the implementation of the Human Resources for Health Policy interventions at this facility.

Our discussion will focus on your decision role and outcomes associated with the policy instruments of the Human Resource for Health Strategic Plan implemented between 2009 and 2014 at your facility.
Specific focus will be on the following:
Result area 1- Human Resources Planning and Financing;
Result area 2- Production, Training and Development of Human Resources for Health;
Result area 3- Deployment, Retention, Utilization and Management; and
Result area 4- Human Resource Information and Research.

RESULT AREA ONE: HR PLANNING AND FINANCING

5	Which retention incentives did you receive from your employer between 2009 and 2014? *Circle all that apply*	Stand 1 House 2 Study loan 3 Vehicle 4 Free accommodation 5 Housing allowance 6 Transport to workplace 7 Transport allowance 8 Protective clothing 9 Tax subsidies on vehicle purchase 10 Medical aid 11 Overtime allowance 12 None 5	
	Explain	Probe on how they are determined and key actors in determination?	
6	What retention incentives did you provide your staff between 2009 and	Probe for: -adequate accommodation;	

	2014?	-staff loans for housing and transport; -provision of competitive salaries pegged to regional scales; -housing allowance for staff; -transport allowance; -adequate clothing; -tax subsidies/exemption on vehicles for eligible staff; -subsidised medical costs; -honour conditions of service; -rest; and -tax exemption, allowances and incentives. Probe on how they are determined and key actors in the determination process?	
7	May you please explain any other retention incentives that you or your employees received from your employer between 2009 and 2014? [Probe on their impact on employer and their work]		
8	Are you satisfied with your current salary scale and employment benefits?	Yes 1 No 2	
	Explain		
9	What further changes if any would you want to see in your salary scale?	Probes: -Benchmarking with SADC Levels -comparison with the private sector -How you would want the salary scale to be determined.	
10	Looking at the period between 2009 and 2014, what changes are you most satisfied with at your workplace?	Probes: Do these emanate from your policy decisions or those of either the Local Board, District Medical Office, Provincial Medical Office or Health Ministry	
12	Looking at the same period, in what aspects of your job would you require to see any further changes? [Probe for areas where there were changes/ and	Probes: What policy decisions should be made and by who?	

	no changes at all too].		
13	Given the current state of affairs, are you considering leaving your current job in the near future?	Yes 1 No 2 Not sure 3	
	Explain		
14	Do you have any plans to leave your job in the near future?	Yes 1 No 2 Not sure 3	
	Explain		
15	[If yes to question 47 above] Where are you planning to go?	Local Private Health Sector 1 Local NGO Health Sector 2 Neighbouring countries 3 Overseas 4 Change of Profession 5 Not sure 6	
	Explain		
16	Do you have an HIV/AIDS Policy for workers at your workplace?	Yes 1 No 2 Dont know 3	
17	How has this policy impacted your work and employees at your facility? [Explain]		

RESULT AREA TWO: TRAINING AND DEVELOPMENT

18	On what aspects do you require further training as a facility manager?	Probe for: [organizational, individual, task needs]	
19	How is the lack of training on these aspects affecting your work/ organization?	Probe for: [tasks not able to be done that could be done at this level]	
20	On what aspects do you think your employees require training?	Probe for: [organizational, individual, task needs]	
21	How is the lack of training on these aspects affecting their work at this facility organization?	Probe for: [tasks not able to be done that could be done at this level]	

22	Looking at the period between 2009 and 2013, what on the job training have you received?	Probe for: [workshops, conferences and agenda]	
23.	How was the conduct of this training determined?	Probe for: [Main decision actors at local community, district, province or national level]	
24.	Looking at the same period, have you enrolled for any of the following courses?	Certificate 1 Diploma 2 Higher National Diploma 3 Undergraduate Degree 4 Masters Degree 5 PhD 6	
	Explain		
25	How was your enrolment determined?	Probe for: [Decision actors either self, local board, district, province or national level]	
26	Looking at the period between 2009 and 2013, what on the job training has your staff at this facility received?	Probe for: [workshops, conferences and agenda]	
27	How was the conduct of this training determined?	Probe for: [Main decision actors at local community, district, province or national level]	
28	Looking at the same period, how many of your staff have you enrolled for any of the following courses?	Certificate 1 Diploma 2 Higher National Diploma 3 Undergraduate Degree 4 Masters Degree 5 PhD 6	
29	What support are they receiving from for enrolment?	Probe for: [study loan, reduced working hours, fees waiver, study allowance, scholarship, bursary, study leave]	
30	How was the enrolment for this training determined?	Probe for: [Main decision actors either being self, local board, district, province or national level]	
31	How is this training impacting on the work by your facility?		
32	What training and study opportunities would you want for yourself and your employees?		

RESULT AREA THREE: DEPLOYMENT, RETENTION AND MANAGEMENT

33	How are your current staffing levels for various health cadres at this facility determined?	Probe for; [Main decision actors either being self, local board, district, province or national level]	
34	How do your current staffing levels compare with requirements for your facility?	Probe for; [staffing requirements, staff shortages, skills shortfalls, numbers available against unavailable]	
35	May you explain attraction and retention practices at your facility?	Probe for: [Outcomes, challenges, prospects]	
36	How are these attraction and retention practices determined?	Probe for: [Main decision actors either being self, local board, district, province or national level]	
37	May you explain the performance management system (appraisal system) used at your workplace?		
38	How is this system determined?	Probe for: [Main decision actors either being self, local board, district, province or national level]	
39	Have you received training on the implementation of the results based worker performance management system from the Ministry of Health and Child Care?	Yes 1 No 2	
	Explain		

RESULT AREA FOUR: HUMAN RESOURCE INFORMATION AND RESEARCH

40	May you explain your knowledge and perception regarding the implementation of Human Resources for Health Information System/ Health Workforce Observatory by the Ministry of Health and Child Care?	Probe for: [components, rationale and impact on work]	
41	What do you think should be done to effectively and efficiently implement this Human Resource for Health	Probe on: [Decentralization or centralized implementation]	

	Information System/ Observatory?	Probe for: [components, rationale and levels of implementation]	

Finally, let us now comparing the HRH situation:
-before 2010; and
-the situation between 2010-2014.

42. HEALTH PERSONNEL SERVICE OUTCOMES

a. AVAILABILITY	**Probes**
How was the availability of health personnel at this facility 2009?	Adequacy of cadres: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
How was the availability of health personnel in this community between 2009 and 2014? Were there positive/negative changes? Improved availability/no improvement?	Adequacy of cadres: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians];

	and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
What were the drivers for these changes on availability between 2009 and 2014?	Probe on decisions made by -who; -when; -how; and -for which cadres
What are your recommendations on availability?	Adequacy of cadres: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]

b. AFFORDABILITY	**Probes**
How was the affordability of services by health personnel in this community before 2009?	Affordability of services by: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists,

	Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
How was the affordability of services by health personnel in this community between 2009 and 2014? Did they become more affordable/ less affordable?	Affordability of services by: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]
What were the drivers for these changes on affordability between 2009 and 2014?	Probe on decisions made by -who; -when; -how; and -for which cadres
What are your recommendations on affordability of services?	Affordability of services by: • Nurses (Registered General Nurses, State Certified Midwives, Psychiatry Nurses, and Primary Care Nurses if applicable); • Doctors (Specialist and General); • [Environmental Health Officers, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians,

	Rehabilitation Technicians]; and • [Radiographers, X-Ray Operators, Occupational Therapists, Medical Laboratory Scientists, Programme Managers, and Research Officers.]

THANK AND END

END TIME:_____

SEMI-STRUCTURED QUESTIONNAIRE FOR HEALTH CARE PERSONNEL
[Health Cadres at Health Facilities]

INTRODUCTION

Good morning/afternoon. My name is_____ and I am a student from the University of Pretoria. I am currently undertaking an academic survey as part of my PhD studies to examine the human resource management policy interventions and their implications for the optimization of the health system at a community level with specific focus on Epworth. May you please feel free to participate in this project. The information you provide will be treated in confidence and for this academic purpose only.

Our discussion will focus on assessing the impact of human resources for health strategic policy interventions on performance and practices in the health system.

What is the impact of the specific instruments
Looking at the interventions between 2009-2014 to what extent have these impacted on your work.

I also kindly ask for your permission to record our discussion so that l may be able to capture some things that l might miss during note taking.

Our discussion will take about fifty minutes of your time.

HEALTH FACILITY	
Type of facility Hospital 1 Health Centre 2 Health Clinic 3 Mobile Clinic 4 Local private clinic 5 Other (specify) _____7	Facility operated by Local Government 1 Private for profit organization 2 Non Government Organization 3 Religious Organization 4 Other (Specify)_____5
Ward number	
Date	
What is you date of birth?	Month Year
Lastly, some additional information for use in statistical interpretation of your responses. *RECORD SEX AS OBSERVED*	Male 1 Female 2
Occupation of respondent (Cadre)	Doctor 1 Registered General Nurses 2 State Certified Midwives 3 Psychiatry Nurses 4 Primary Care Nurses 5 Environmental Health Officers 6 Pharmacists 7

	Physiotherapists 8 Nutritionists 9 Laboratory Technicians 10 Rehabilitation Technicians 11 Clinical Officer 12 Nurse Aides 13 Primary Counsellors 14 Dispensary Assistant 15 Dental Surgeon 16 Laboratory Technician 17 Radiographers 18 X-Ray Operators 19 Occupational Therapists 20 Medical Laboratory Scientists 21 Programme Managers 22 Research Officers 23 Other (Specify) _____ 24

WORK STATUS, CONDITIONS AND QUALIFICATIONS

	Question	**Response Code**	**Skip to**
1	I would like to start by asking you about your work as a health care provider at this facility. How would you describe your **occupation** at this facility?	Explain:	
2	What **level of health care** do you provide?	Auxiliary 1 Tertiary (Specialist Care) 2 Secondary (General Skilled) 3 Primary (General Unskilled) 4 Other (Specify) 5	
3	Which services do you **mainly personally** provide at this facility?	Preventive 1 Promotive 2 Rehabilitative 3 Curative 4 Other (Specify) 5	
4	What was the highest level of schooling you reached to become a practicing health care provider?	Certificate 1 Diploma 2 Undergraduate Degree 3 Masters Degree 4 Doctorate 5 Other (Specify) 6	
5	In what year did you reach this level?	Year:	
6	In what country did you reach this level?	Country of work location 1 Other country (specify) 2	→ 8
7	In which school did you reach this	Name of school	

	level?		
8	a.)How many hours week do you usually work at this facility in a given week, excluding unpaid mealtimes and on call hours? (on call hours are those which include nights and weekends when you must be available for duty but do not have to be physically present at the health facility except when the patient requires it)	Hours	
	b.)Did you work on-call hours at this facility in the last 30 days? IF YES: How many on call hours did you work here in the past 30 days?	Hours None 0	
9	What type of work do you usually do at this facility for pay?	Direct patient care 1 Consultation with agencies 2 Administration/Supervision 3 Teaching 4 Research 5 Laboratory/diagnostic procedures 6 Dispensing 7 Other (Specify) 8 Not paid for work 9	▶ 10 ▶ 11 ▶ 11 ▶ 11 ▶ 11 ▶ 11 ▶ 11 ▶ 11
10	How many patients have you personally seen here in the last 30 days	Number Dont know 9998	
11	How would you describe the method by which you usually paid at this facility?	Salary 1 Fee for service only 2 Capitation (fixed per patient) 3 Capitation plus fees for extra services 4 Other (Specify) 8	
12	For which types of services do you usually receive extra fees?	Dispensed medicines 1 Other medical supplies/consumables 2 Immunizations 3 Laboratory/diagnostic procedures 4 (Specify) 8	▶ 13 ▶ 13 ▶ 13 ▶ 13 ▶ 13
13	I am interested in knowing the average income of health workers and people trained in the health field. Remember that whatever you say is confidential and will be used only for research purposes. Thinking over the past year, can you	Per week _____ Per month _____ Per year _____ Refuse	

	tell me what your average earnings from working at this facility have been? Please tell me the amount per week or per month or per year, whichever is easiest for you.	9998 Dont know 9999	
14	Over the past 12 months, have you experienced a delay in receiving your pay as scheduled from your employer?	Yes 1 No 2 → 16 Not applicable 3 → 16	
15	How long would you say the delays have lasted on average?	Number of Days _____ Number of Weeks _____ Number of months	
16	Do you receive any of the following additional benefits from working here? *READ OUT ALL*	Yes No Allowance for meals 1 2 Allowance for housing 1 2 Allowance for transport 1 2 Paid vacations 1 2 Medical aid 1 2	
	MOTIVATION ASSESSMENT		
17	How satisfied are you with the following aspects of your job?		
	Physiological needs *(eg pay, bonus, allowances)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Security needs *(job security, safety at the workplace, protection from contracting diseases, medical aid)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Social needs *(feeling of belongingness to the facility's formal or informal groups)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Esteem needs *(job titles, association with health facility, association with community)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Self actualization *(opportunity to participate in decision making, opportunity to advance in career)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	

	DECISION MAKING		
18	Do you participate in decision making at your workplace?	Yes 1 No 2	→
19	Do you feel that you enjoy decision space in your workplace or that most of the things are already determined for you in advance?	Enjoy decision space 1 No decision space 2	
20	How much decision space do you have on the following aspects of your work?		
	Health financing *(eg salary determination, fee determination, facility budget)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Medical products, vaccines and technology *(ie Procurement, allocation and disbursement)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Human resources *(ie staffing levels, needs, working conditions, recruitment procedures, training, promotion, deployment, remuneration)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Health information systems *(ie procedures to acquire health information from the community, procedures to disseminate health information to community, type of health information etc)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Leadership *(ie participation in strategy formulation, operational plans formulation, work procedures, protocols)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Service delivery *(ie hours and days of operation, conditions of operation)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	MEMBERSHIP TO BODIES AND TRAININGS		
21	Are you currently registered with any Health Professional Association?	Yes 1 No 2	
22	If yes; Specify the association?		→
23	Are you currently a member of any professional associations	Yes 1 No 2	

24	Between 2009 and 2014, have you been in any health/medical professional training or continuing education programmes?	Yes No	
	Explain		
25	For how many days (in the last 12 months) have you been on such programmes?		
	Explain		
	SECONDARY EMPLOYMENT		
26	Now 1 would like to ask you some questions about your work activities at other locations. In addition to your work at this facility, have you worked at another location in the last 30 days?	Yes 1 No 2	→
27	How would you best describe this other place where you worked?	Government Hospital 1 Government Health Centre 2 Government Health Post 3 Government Mobile Clinic 4 Other Public Health Facility(Specify) 5 Private/NGO Hospital 6 Private/NGO Health Clinic 7 Private/NGO Mobile Clinic 8 Private Office 9 Other Private Health Facility(Specify) 10 Pharmacy 11 Other non health facility (Specify) 12	
28	a.)How many hours per week do you usually work at this other location excluding unpaid mealtimes and on call hours?	Hours	
	b.) Did you work on call hours at this other location in the last 30 days? IF YES, how many on call hours did you work there in the last 30 days?	Hours None 0	

29	What type of work do you usually do at this other location for pay? *(CIRCLE ALL THAT APPLY)*	Direct patient care 1 Consultation with agencies/ Professionals 2 Administration/supervision 3 Teaching 4 Research 5 Laboratory/Diagnostic Procedures 6 Dispensing 7 Other (specify) 8 Other (specify) 9 Not worked for pay 10 →	
30	How would you describe the method by which you are usually paid at this other location?	Salary 1 → Fee for service only 2 → Capitation (fixed per patient) 3 → Capitation plus fees for extra fees 4 Other (Specify) 5 →	
31	For which types of services do you usually receive extra fees there? *CIRCLE ALL THAT APPLY*	Dispensing medicines 1 → Other medical supplies/consumable 2 Immunizations 3 Laboratory/Diagnostic Procedures 4 Others (Specify) 5	
32	What are your average earnings from working at this second location? Please tell me the amount per week or per month or per year whichever is easiest for you. (Remember that whatever you say is confidential and will be used only for research purposes)	Per Week _____ Per Month _____ Per Year _____ Refuse 9998 Dont know 9999	
33	Do you receive any of the following additional benefits from working there? *READ EACH TYPE OF BENEFIT AND RECORD ALL ANSWERS*	YES NO Allowances for meals 1 2 Allowances for housing 1 2 Allowances for Transportation 1 2 Paid vacations 1 2 Medical aid 1 2	
	MOTIVATION ASSESSMENT		
34	How satisfied are you with the following aspects of your job at this other facility?		
	Physiological needs *(eg pay, bonus, allowances)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Security needs *(job security, safety at*	Strongly satisfied 1	

	the workplace, protection from contracting diseases, medical aid) *READ OUT*	Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Social needs *(feeling of belongingness to the facility's formal or informal groups)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Esteem needs *(job titles, association with health facility, association with community)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	Self actualization *(opportunity to participate in decision making, opportunity to advance in career)* *READ OUT*	Strongly satisfied 1 Somewhat satisfied 2 Satisfied 3 Somewhat dissatisfied 4 Totally dissatisfied 5	
	DECISION MAKING		
35	Do you participate in decision making at this other workplace?	Yes 1 No 2	
	Do you feel that you enjoy decision space in your workplace or that most of the things are already determined for you in advance?	Enjoy decision space 1 No decision space 2	
36	How much decision space do you have on the following aspects of your work?		
	Health financing *(eg salary determination, fee determination, facility budget)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Medical products, vaccines and technology *(ie Procurement, allocation and disbursement)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Human resources *(ie staffing levels, needs, working conditions, recruitment procedures, training, promotion, deployment, remuneration)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Health information systems *(ie procedures to acquire health information from the community,*	Total space 1 More space 2 General space 3	

	procedures to disseminate health information to community, type of health information etc)	Less space 4 No space at all 5	
	Leadership *(ie participation in strategy formulation, operational plans formulation, work procedures, protocols)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
	Service delivery *(ie hours and days of operation, conditions of operation)*	Total space 1 More space 2 General space 3 Less space 4 No space at all 5	
37	I would like to ask a few questions about your work experience. How many years of experience do you have in practice as a health care provider?	Years	
38	For how long have you been working at this facility here? *RECORD IN WEEKS, MONTHS OR YEARSAS ANSWERED*	Number of weeks Number of months Number of years	
39	How would you describe the last place where you worked before coming to this facility?	Government hospital 1 Government health centre 2 Government health post 3 Government mobile clinic 4 Other government health facility (Specify) 5 Private/NGO Hospital 6 Private/NGO health clinic 7 Private mobile clinic 8 Private office 9 Other private health (Specify) 10 Pharmacy 11 Other non health (Specify) 12 Same as current secondary place 13	
40	What type of work did you usually do at that last location for pay?	Direct patient care 1 Consultation with agencies/ Professional 2 Administrative/supervision 3 Teaching 4 Research 5 Laboratory/diagnostic Procedures 6 Dispensing 7 Other (Specify) 8	

		Not applicable/not paid 9	
41	Where was your former work located?	In the same city/rural district 1 In a different city 2 In a different rural district 3 In another country (Specify) 4	

Finally, let us discuss how the Human Resource for Health Strategic Plan of 2010 to 2014 has impacted on your work. On this, I am mainly looking for changes and outcomes that you have experienced in your work.

RESULT AREA ONE: HR PLANNING AND FINANCING

42	Which benefits have you received from your employer between 2009 and 2014? *Circle all that apply*	Stand 1 House 2 Study loan 3 Vehicle 4 Free accommodation 5 Housing allowance 6 Transport to workplace 7 Transport allowance 8 Protective clothing 9 Tax subsidies on vehicle purchase 10 Medical aid 11 Overtime allowance 12 None 13	
	Explain		
45	May you please explain any other benefits that you received from your employer between 2009 and 2014? [Probe on their impact on employer and their work]		
44	Are you satisfied with your current salary scale and employment benefits?	Yes 1 No 2	
	Explain		
45	What changes if any would you want to see in your salary scale?		
46	Looking at the period between 2009		

	and 2014, what changes are you most satisfied with at your workplace?		
47	Looking at the same period, in what aspects of your job would you require to see any further changes? [Probe for areas where there were changes/ and no changes at all too].		
46	Given this, are you considering leaving your current job in the near future?	Yes 1 No 2 Not sure 3	
	Explain		
47	Do you have any plans to leave your job in the near future?	Yes 1 No 2 Not sure 3	
	Explain		
48	[If yes to question 47 above] Where are you planning to go?	Local Private Health Sector 1 Local NGO Health Sector 2 Neighbouring countries 3 Overseas 4 Change of Profession 5 Not sure 6	
	Explain		
49	Do you have an HIV/AIDS Policy for workers at your workplace?	Yes 1 No 2 Dont know 3	
50	How has this policy impacted your work? [Explain]		

RESULT AREA TWO: TRAINING AND DEVELOPMENT

51	On what aspects do you require further training? [Probe on organizational, individual, task needs]		
52	How is the lack of training on these aspects affecting your work?		
53	Looking at the period between 2009		

	and 2013, what on the job training have you received? [probe for workshops, conferences and agenda]		
54	Looking at the same period, have you enrolled for any of the following courses?	Certificate 1 Diploma 2 Higher National Diploma 3 Undergraduate Degree 4 Masters Degree 5 PhD 6	
	Explain		
55	What support are you receiving from your employer for enrolment? [Probe for study loan, reduced working hours, fees waiver, study allowance, scholarship, bursary, study leave]		
56	How is this training impacting on your work?		
57	What training and study opportunities would you want from your employer?		

RESULT AREA THREE: DEPLOYMENT, RETENTION AND MANAGEMENT

58	Are you aware about the worker performance management system (appraisal system) used at your workplace?	Yes 1 No 2	
	Explain		
59	Have you received training on the implementation of the results based worker performance management system?	Yes 1 No 2	
	Explain		
60	May you please explain practices adopted by your employer between 2009 and 2014 to retain workers at your workplace?		
61	How are these practices impacting on your work? [Probe on outcomes too]		

RESULT AREA FOUR: HUMAN RESOURCE INFORMATION AND RESEARCH

62	May you explain your knowledge and		

	perception regarding the implementation of Human Resources for Health Information System/ Health Workforce Observatory by the Ministry of Health and Child Care? [Probe on components, rationale and impact on work]		
63	What do you think should be done to effectively and efficiently implement this Human Resource for Health Information System/ Observatory?		

THANK AND END

END TIME:

FOCUS GROUP DISCUSSION GUIDE COMMUNITY MEMBERS

INTRODUCTION

Good morning/afternoon. My name is_____ and I am a student from the University of Pretoria. I am currently undertaking an academic survey as part of my PhD studies to examine the implementation of the Human Resources for Health Strategic Plan 2010-2014, and its impact on your ward. The information you provide will be treated in confidence and for this academic purpose only.

Our discussion will focus on:

- your decision role in the implementation of the aforementioned intervention; and
- impact on your community/ ward.

May you please note that our discussion may take about an 30 minutes. I also kindly ask for your permission to record our discussion so that l may be able to capture some things later on that I might miss during the interview.

Note: Recruitment criteria is as follows; adult community members male and female who have lived in Epworth before 2009, and between 2009 and 2014; and have used local health facilities during the same time.

Record Ward number here_____

To start with, let us talk about your Community/ Ward's public health situation analysis before and after 2009.

Community Public Health Situation Analysis	**Probes**
1. What were the main community health challenges before 2010?	-Causes and drivers of the challenges; -Health system; -Infrastructure and community set up; and -Communicable and non communicable diseases.
2. What were the main community health challenges between 2010 and 2014?	-Causes and drivers of the challenges; -Health system; -Infrastructure and community set up; and -Communicable and non communicable diseases.
3 Who were the main health service providers in this community/ ward before 2010.	-Government facilities; -Local municipality; -Private for profit; -Non Government Organizations including missions; -Community Health

	Workers; and -The informal.
4. Who were the main health service providers in this community/ ward between 2010 and 2014?	-Government facilities; -Local municipality; -Private for profit; -Non Government Organizations including missions; -Community Health Workers; and -The informal.
5. What decision forums exist in this ward for members to participate in Human Resource for Health policy interventions in this community/ ward?	-Community Groups; -Church Groups; -Community Health Committees; -Public meetings; -Door to door consultations; -etc

Let us now proceed to discuss about the implementation of the Human Resources for Health Policy interventions in this community/ ward.

Our discussion will focus on your decision role and outcomes associated with the policy instruments of the Human Resource for Health Strategic Plan implemented between 2010 and 2014.

Specific focus will be on the following:
Result area 1- Human Resources Planning and Financing;
Result area 2- Production, Training and Development of Human Resources for Health;
Result area 3- Deployment, Retention, Utilization and Management; and
Result area 4- Human Resource Information and Research.

---

6. What was your decision role on the following in this community/ ward:

a. Human Resource Planning and Financing	
	Probes
Determination of the of HRH policy operational frameworks? ***For example*** Stakeholder consensus meetings on the HRH Strategic Plan; Engagement of UN and partners to finance training of HW;	Determination of the HRH policy operational frameworks in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers;

Development of intermediate and costed annual operating work plans; and Progress review meetings.	-voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this ward? Policy outputs; Outcomes; and Impacts.
Determination of Policies and Strategies on the attraction and retention of health personnel, and improvement of working conditions? ***For example*** Review of attraction and retention policies; Lobby stakeholders on stands, houses, vehicles and study loans; Benchmark salaries to SADC levels; and Lobby parliament for more funding.	Determination of attraction and retention operational frameworks for this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Management of the impact of HIV and AIDS on HRH in the health service? ***For example*** Development and implementation of an HIV/AIDS workplace policy; and Development and implementation of a biosafety and bio security policy for HRH.	Determination of the management frameworks for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Establishment of the platform for strategic partnerships on HRH with national, regional, continental, and international groupings ***For example***	Establishment of the platform in this community/ ward for: -government health workers*;* -local government *(council/*

Platform/technical working groups for HRH; and Collaborative projects for training, recruitment and compensation with other international and regional organizations.	*municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Review framework for health worker skills mix for the country/ province/ district/ community based on prevailing needs within the region? ***For example*** Train Managers and HR Staff in workforce planning; and Review skills mix for planning purposes.	Review of frameworks in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Updating and use of the HRH Information system to assist planning and to rationalise all HRH management functions? ***For example*** Baseline study to determine the use of ICT for HRH; Development of a framework for use of ICT in HRH; and Development of a national HRH database.	Updating of the HRHIS in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.

Establishment of the HRH Observatory? ***For example*** Appointment of a working group.	Role in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.

b. Production, Training and Development of Human Resources for Health	
	Probes
Strengthening capacity for training of critical human resources for health? ***For example*** Conduct skills audit; Review of staffing norms for the health sector and training institutions; Development of a 10 year HRH master plan; Development/review, implementation of training standards and monitor the minimum standards for training schools; Training of the appropriate categories of HWs to match the national HRH need; and Solicit funding for training institutions.	Strengthening of capacity in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Increase production output of health workers with critical post basic and postgraduate qualifications? ***For example*** Training, and to fund training, of: Lecturers and tutors; Midwives; Clinical officers; Nurses; and Doctors.	Role in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this

	community/ ward? Policy outputs; Outcomes; and Impacts.
Support of health workers to undertake Diploma/Higher National Diploma programmes?	Supporting role in this community/ ward for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Identification, development and establishment of centres of specialization? ***For example*** Establishment of a baseline on existing and potential centres of specialization; and Identification of staff categories to be trained in the first five year period.	Role in this community/ ward for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Development and implementation of national frameworks and mechanisms for exchange programmes and attachments? ***For example*** Establishment of a baseline on existing and potential centres of specialization; and Identification of staff categories to be trained in the first five year period.	Role in this community/ ward for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)*

	workers; and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Development and implementation of induction programmes ***For example*** Development of an induction manual for all new staff.	Role in this community/ ward for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Training of all managers in leadership and management skills ***For example*** Training on: -health service regulations; -management skills; -computer skills; -succession planning; -short courses, seminars and workshops abroad; -M&E; and -HRHIS.	Role in this community/ ward for: -government health workers; -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers; and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.

c. Deployment, Retention, Utilization and Management	
	Probes
Ensuring equitable recruitment/employment of staff? ***For example***	Role in this community/ ward for:

-decentralization of recruitment functions for selected levels; and -review of recruitment guidelines of qualified foreign health personnel.	-government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Ensuring equitable deployment of staff? ***For example*** -Review of deployment criteria for graduates.	Role in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Ensuring equitable retention/motivation incentives (intrinsic and extrinsic incentives) for staff? ***For example*** Provision of: -adequate accommodation; -staff loans for housing and transport; -provision of competitive salaries pegged to regional scales; -housing allowance for staff; -transport allowance; -adequate clothing; -tax subsidies/exemption on vehicles for eligible staff; -subsidised medical costs; -honour conditions of service; -rest; and -tax exemption, allowances and incentives.	Role in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Ensuring equitable management and utilization of staff	Role in this community/ ward

For example -implementation of the results based performance management system; and -expedite disciplinary procedures.	for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.

d. Human Resource Information and Research	
	Probes
Development and strengthening of the HRHIS to assist planning and to rationalise all HRH management functions. ***For example*** -Development of a national framework for the HRHIS including a National Observatory; -Establishment of a Zimbabwean Health Workforce Observatory; -Development and implementation of a national HRHIS; and -Assessment of the current Human Resource System in the country.	Role in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward? Policy outputs; Outcomes; and Impacts.
Provide data and information for evidence based policy formulation, planning and management of HRH. ***For example*** -Conduct of a desk review of current HR studies; -Development of a National HRH research agenda; -Mobilization of resources for HRH Research; and -Contribution to articles for HSB, Ministry and regional organizational websites.	Role in this community/ ward for: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this

	community/ ward? Policy outputs; Outcomes; and Impacts.

Finally, we are now comparing the HRH situation:
-before 2010; and
-the situation between 2010-2014.

7. HEALTH PERSONNEL SERVICE OUTCOMES

AVAILABILITY	**Probes**
How was the availability of health personnel in this community/ ward before 2010?	Adequacy of: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?
How was the availability of health personnel in this community/ ward between 2010 and 2014?	Adequacy of: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?
What are your recommendations on availability?	For government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and -community health workers in this community/ ward?

AFFORDABILITY	**Probes**
How was the affordability of services by health personnel in this community/ ward before 2010?	Affordability of services by: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?
How was the affordability of services by health personnel in this community/ ward between 2010 and 2014?	Affordability of services by: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?
What are your recommendations on affordability of services?	For government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?

ACCESIBILITY	**Probes**
How was the accessibility of health personnel in this community/ ward before 2010?	Accessibility of: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?

How was the accessibility of health personnel in this community/ ward between 2010 and 2014?	Accessibility of: -government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?
What are your recommendations on accessibility?	For government health workers*;* -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?

ACCEPTABILITY	**Probes**
How was the acceptability of health personnel in this community/ ward before 2010?	Acceptability of services by male, female, junior, senior health personnel from: -government health facilities; -local government *(council/ municipality)* facilities; -private for profit health facilities; -voluntary sector *(Faith based organization, NGOs, informal)* facilities*;* and community health workers in this ward?
How was the accessibility of health personnel in this ward between 2010 and 2014?	Acceptability of services by male, female, junior, senior health personnel from: -government health facilities; -local government *(council/ municipality)* facilities; -private for profit health

	facilities; -voluntary sector *(Faith based organization, NGOs, informal)* facilities*;* and community health workers in this community/ ward?
What are your recommendations on accessibility?	For services by male, female, junior, senior health personnel from government health workers from: -local government *(council/ municipality)* health workers; -private for profit health workers; -voluntary sector *(Faith based organization, NGOs, informal)* workers*;* and community health workers in this community/ ward?

THANK AND END

INFORMED CONSENT FORM ONE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Health Sciences

School of Health Systems and Public Health

INFORMED CONSENT FORM FOR ADULT NATIONAL, PROVINCIAL AND DISTCRICT POLICY MAKERS

[DIRECTOR OF HUMAN RESOURCE FOR HEALTH POLICY FOR THE MINISTRY OF HEALTH AND CHILD CARE] [DIRECTOR OF HUMAN RESOURCE FOR HEALTH FOR THE HEALTH SERVICES BOARD] [PROVINCIAL MEDICAL OFFICER] [DICTRICT MEDICAL OFFICER] [ZIMBABWE ASSOCIATION OF CHURCH HOSPITALS] [HEALTH PROFESSIONS ASSOCIATION] [ACADEMIC COMMUNITY] [OTHER MINISTRIES AND ASSOCIATIONS]

PROJECT TITLE:

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

Principal Investigator:

Hope Taderera [Special Med MPH (UP), MPA (UZ)]

Contact Details:

+263 718 177 337

htaderera@gmail.com

Research Ethics Committee

Faculty of Health Sciences

University of Pretoria

+27 12 354 1330

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What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.
- Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient. The main goal of research studies is to gain knowledge that may help future patients.
- We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Whatever you decide, it will not affect your regular care.
- Please read this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

ETHICAL APPROVAL

Permission to carry out this study has been granted by the Ministry of Health and Child Care (MHCC); Health Services Board (HSB); Medical Research Council of Zimbabwe (MRCZ); the Provincial Medical Directorate of Mashonaland East; Seke Rural District Medical Directorate; the Epworth Local Board; Academic Advisory, and the Research Ethics Committees of the Faculty of Health Sciences, University of Pretoria, South Africa.

The research also complies with the ethical norms of bodies that protect the interests of research participants like you, for example the Medical Research Council and the Health Professions Council of South Africa and the Declaration of Helsinki (last updated October 2000) which gives guidelines to doctors doing research with people.

PURPOSE

You are being asked to participate in an academic study of the PhD in Public Health Programme that I am enrolled for at the above-mentioned institution. The aim of this study is to examine decision space and its impact in the implementation of human resource for health

interventions in the context of semi formal/ peri-urban communities. Analysis will focus on the implementation of the Human Resource for Health Strategic Plan (2010-2014) of the 2009 Human Resources for Health Policy in Zimbabwe. You were selected to participate in this study because you are a policy maker. Other participants in this study include the Local Community Human Resource for Health from Epworth Local Board; the Community Health Officer for Epworth; seven Health Facility Managers from Epworth; a sample of 146 Nurses from health facilities across Epworth; six District Health Cadres who include the Environmental Health Officer, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, and Rehabilitation Technicians; and 70 Adult Focus Group Discussion Participants to be drawn from Epworth.

NATURE

The aim of this study is to examine decision space and its impact in the implementation of the Human Resource for Health Policy in Epworth, Zimbabwe between 2009 and 2014. Decision Space Mapping Analysis will be used to examine data.

This study will contribute to the on-going research track activities of the Health Policy and Management of the School of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria. It will also contribute to the Human Resource for Health policy in Zimbabwe and beyond. You as a participant are a very important source of information on this topic.

PROCEDURE AND DURATION

If you decide to participate, you will undergo a Key Informant Interview in which I will ask some questions using an interview guide. I also kindly ask to record our conversation so that l may be able to catch up on things that l may miss out on during our discussion. The interview will take about an hour of your time. A follow up interview may be held if need be. Participation may also involve photography of Human Resource for Health artifacts from your organization. The photos will be used for purposes of this study only. However, you also have the right to refuse to have these photos taken or to be recorded. There will be no consequence to you for your refusal

RISK AND DISCOMFORT INVOLVED

The risk may include the potential for your discomfort during participation due to the fear associated with the prevailing socio-political environment in Zimbabwe. On this, I assure you that the findings will be used specifically for the academic purposes of this study, and that your confidentiality will be protected throughout to the effect that findings will not be directly related to you. There is also a risk that your participation will disrupt your work. To minimize this, prior arrangements have been made and effort will also be made to ensure that the interview will take an hour as advised. Arrangements may also be made to re-schedule the interview if need be. Some of the questions we are going to ask you may make you feel uncomfortable, but you need not answer them if you don't want to.

BENEFITS AND/OR COMPENSATION

Your participation is voluntary. I do not promise or guarantee that you will receive any direct benefits from this study. However, findings will benefit you indirectly from Human Resource for Health Policy recommendations based No compensation or contribution towards your transport expenses will be given for your participation.

However, the results of the study will be reported back to you upon completion of this study. In the event that the questions asked cause emotional distress to you, then the researcher will refer you to a competent counsellor for counselling.

YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you or your treatment in any way.

ALTERNATIVE PROCEDURES OR TREATMENTS

The interview may be stopped at any point for your convenience and arrangements may be made to re-schedule or cancel it if need be.

CONFIDENTALITY

If you indicate willingness to participate in this study by signing this document, I plan to disclose findings to the Faculty of Health Sciences at the University of Pretoria, Medical

Research Council of Zimbabwe and Epworth Local Board. Findings will be reported to the International Development Research Centre, African Population and Health Research Centre, Faculty of Health Sciences at the University of Pretoria, and Epworth Local Board. Research findings will also be made to the Ministry of Health and Child Care of Zimbabwe, Health Services Board of Zimbabwe, Department of Health in South Africa, South African National Aids Council, and the World Health Organization's Regional Office for Africa. Other ways of reporting the research findings to have practical policy and action impacts will also be collaboratively sought in discussion with participants and stakeholders to be involved in this study. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your Permission. However, for purposes of examination, this information will be disclosed to the School of Health Systems and Public Health, Faculty of Health Sciences at the University of Pretoria.

ADDITIONAL COSTS

There are no costs for your participation. However, if there is a possibility of there being costs, these will be met by the lead researcher of this project.

IN THE EVENT OF INJURY

In the event of injury resulting from your participation in this study, treatment shall be offered by this study. In the event of injury, contact the lead researcher on 0718 177 337 who is available 24 hours per day to help attend to your injury.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with any of the stakeholders involved. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without consequences or penalties.

ADDITIONAL ELEMENTS

There are no consequences for your decision to withdraw from the research. This decision to withdraw may be made verbally. You may withdraw from the research if it interferes with your work, become ill or if for whatever reason it is not in your interest to participate, even

when prior arrangements for your participation would have been made by way of booking for an appointment.

SIGNATURE PAGE

PROJECT TITLE

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

MRCZ/A/1941

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ _____

Name of Research Participant (please print) Date

_____ _____

Signature of Participant or legally authorized representative Time

_____

Relationship to the Participant

[the above two lines should appear on forms signed by legal representatives of the participant, for example the parents of a minor.]

_____	_____	_____
Name of Staff Obtaining Consent	Signature	Date
_____	_____	_____
Name of Witness (*if required)*	Signature	Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

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 (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Audio, Video Recording and Photography

Statement of Consent to be photographed, Audiotaped or Videotaped.

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to having my **photograph taken** **Yes** ☐ **No** ☐
- I agree to **being audio recorded** **Yes** ☐ **No** ☐
- I agree to having my **video recorded** **Yes** ☐ **No** ☐

[delete the options that are not appropriate for this study]

_____ _____ _____

Name of Participant (please print) Signature Date

INFORMED CONSENT FORM TWO

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Health Sciences

School of Health Systems and Public Health

INFORMED CONSENT FORM FOR ADULT HUMAN RESOURCE FOR HEALTH LOCAL COMMUNITY POLICY MAKERS

[EPWORTH LOCAL BOARD HUMAN RESOURCE FOR HEALTH POLICY MAKER; COMMUNITY HEALTH OFFICER]

PROJECT TITLE:

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Principal Investigator:

Hope Taderera [Special Med MPH (UP), MPA (UZ)]

Contact Details:

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htaderera@gmail.com

Research Ethics Committee

Faculty of Health Sciences

University of Pretoria

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this study because you are a policy maker. Other participants in this study include National and Regional Level Policy Makers, the Community Health Officer for Epworth; seven Health Facility Managers from Epworth; a sample of 146 Nurses from health facilities across Epworth; six District Health Cadres who include the Environmental Health Officer, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, and Rehabilitation Technicians; and 70 Adult Focus Group Discussion Participants to be drawn from Epworth.

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PROCEDURE AND DURATION

If you decide to participate, you will undergo a Key Informant Interview in which I will ask some questions using an interview guide. I also kindly ask to record our conversation so that l may be able to catch up on things that l may miss out on during our discussion. The interview will take about an hour of your time. A follow up interview may be held if need be. Participation may also involve photography of Human Resource for Health artifacts from your organization. The photos will be used for purposes of this study only. However, you also have the right to refuse to have these photos taken.

RISK AND DISCOMFORT INVOLVED

The risk may include the potential for your discomfort during participation due to the fear associated with the prevailing socio-political environment in Zimbabwe. On this, I assure you that the findings will be used specifically for the academic purposes of this study, and that your confidentiality will be protected throughout to the effect that findings will not be directly related to you. There is also a risk that your participation will disrupt your work. To

minimize this, prior arrangements have been made and effort will also be made to ensure that the interview will take an hour as advised. Arrangements may also be made to re-schedule the interview if need be. Some of the questions we are going to ask you may make you feel uncomfortable, but you need not answer them if you don't want to.

BENEFITS AND/OR COMPENSATION

Your participation is voluntary. I do not promise or guarantee that you will receive any direct benefits from this study. However, findings will benefit you indirectly from Human Resource for Health Policy recommendations based No compensation or contribution towards your transport expenses will be given for your participation.

However, the results of the study will be reported back to you upon completion of this study. In the event that the questions asked cause emotional distress to you, then the researcher will refer you to a competent counsellor for counselling.

YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you or your treatment in any way.

ALTERNATIVE PROCEDURES OR TREATMENTS

The interview may be stopped at any point for your convenience and arrangements may be made to re-schedule or cancel it if need be.

CONFIDENTALITY

If you indicate willingness to participate in this study by signing this document, I plan to disclose findings to the Faculty of Health Sciences at the University of Pretoria, Medical Research Council of Zimbabwe and Epworth Local Board. Findings will be reported to the International Development Research Centre, African Population and Health Research Centre, Faculty of Health Sciences at the University of Pretoria, and Epworth Local Board. Research findings will also be made to the Ministry of Health and Child Care of Zimbabwe, Health Services Board of Zimbabwe, Department of Health in South Africa, South African National Aids Council, and the World Health Organization's Regional Office for Africa. Other ways of reporting the research findings to have practical policy and action impacts will also be

collaboratively sought in discussion with participants and stakeholders to be involved in this study. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your Permission. However, for purposes of examination, this information will be disclosed to the School of Health Systems and Public Health, Faculty of Health Sciences at the University of Pretoria.

ADDITIONAL COSTS

There are no costs for your participation. However, if there is a possibility of there being costs, these will be met by the lead researcher of this project.

IN THE EVENT OF INJURY

In the event of injury resulting from your participation in this study, treatment shall be offered by this study. In the event of injury, contact the lead researcher on 0718 177 337 who is available 24 hours per day to help attend to your injury.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with any of the stakeholders involved. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without consequences or penalties.

ADDITIONAL ELEMENTS

There are no consequences for your decision to withdraw from the research. This decision to withdraw may be made verbally. You may withdraw from the research if it interferes with your work, become ill or if for whatever reason it is not in your interest to participate, even when prior arrangements for your participation would have been made by way of booking for an appointment.

SIGNATURE PAGE

PROJECT TITLE

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

MRCZ/A/1941

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ _____

Name of Research Participant (please print) Date

_____ _____

Signature of Participant or legally authorized representative Time

_____

Relationship to the Participant

[the above two lines should appear on forms signed by legal representatives of the participant, for example the parents of a minor.]

_____ _____

_____

Name of Staff Obtaining Consent Signature Date

_____ _____

_____

Name of Witness (*if required)* Signature Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

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 (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Audio, Video Recording and Photography

Statement of Consent to be photographed, Audiotaped or Videotaped.

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to having my **photograph taken** **Yes** ☐ **No** ☐
- I agree to **being audio recorded** **Yes** ☐ **No** ☐
- I agree to having my **video recorded** **Yes** ☐ **No** ☐

[delete the options that are not appropriate for this study]

_____ _____ _____

Name of Participant (please print) Signature Date

INFORMED CONSENT FORM THREE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Health Sciences

School of Health Systems and Public Health

INFORMED CONSENT FORM FOR ADULT HUMAN RESOURCE FOR HEALTH MANAGERS

[LOCAL HEALTH FACILITY HUMAN RESOURCE FOR HEALTH MANAGERS]

PROJECT TITLE:

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

Principal Investigator:

Hope Taderera [Special Med MPH (UP), MPA (UZ)]

Contact Details:

+263 718 177 337

htaderera@gmail.com

Research Ethics Committee

Faculty of Health Sciences

University of Pretoria

+27 12 354 1330

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.

- Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient. The main goal of research studies is to gain knowledge that may help future patients.

- We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.

- You have the right to refuse to take part, or agree to take part now and change your mind later.

- Whatever you decide, it will not affect your regular care.

- Please read this consent form carefully. Ask any questions before you make a decision.

- Your participation is voluntary.

ETHICAL APPROVAL

Permission to carry out this study has been granted by the Ministry of Health and Child Care (MHCC); Health Services Board (HSB); Medical Research Council of Zimbabwe (MRCZ); the Provincial Medical Directorate of Mashonaland East; Seke Rural District Medical Directorate; the Epworth Local Board; Academic Advisory, and the Research Ethics Committees of the Faculty of Health Sciences, University of Pretoria, South Africa.

The research also complies with the ethical norms of bodies that protect the interests of research participants like you, for example the Medical Research Council and the Health Professions Council of South Africa and the Declaration of Helsinki (last updated October 2000) which gives guidelines to doctors doing research with people.

PURPOSE

You are being asked to participate in an academic study of the PhD in Public Health Programme that I am enrolled for at the above-mentioned institution. The aim of this study is to examine decision space and its impact in the implementation of human resource for health interventions in the context of semi formal/ peri-urban communities. Analysis will focus on the implementation of the Human Resource for Health Strategic Plan (2010-2014) of the 2009 Human Resources for Health Policy in Zimbabwe. You were selected to participate in this study because you are a policy maker. Other participants in this study include National and Regional Level Policy Makers, Local Human Resource for Health Policy Maker from the

Epworth Local Board; the Community Health Officer for Epworth; a sample of 146 Nurses from health facilities across Epworth; six District Health Cadres who include the Environmental Health Officer, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, and Rehabilitation Technicians; and 70 Adult Focus Group Discussion Participants to be drawn from Epworth.

NATURE

The aim of this study is to examine decision space and its impact in the implementation of the Human Resource for Health Policy in Epworth, Zimbabwe between 2009 and 2014. Decision Space Mapping Analysis will be used to examine data.

This study will contribute to the on-going research track activities of the Health Policy and Management of the School of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria. It will also contribute to the Human Resource for Health policy in Zimbabwe and beyond. You as a participant are a very important source of information on this topic.

PROCEDURE AND DURATION

If you decide to participate, you will undergo an In-depth Interview in which I will ask some questions using an interview guide. I also kindly ask to record our conversation so that l may be able to catch up on things that l may miss out on during our discussion. The interview will take about an hour of your time. A follow up interview may be held if need be. Participation may also involve photography of Human Resource for Health artifacts from your organization. The photos will be used for purposes of this study only. However, you also have the right to refuse to have these photos taken or to be recorded. There will be no consequence to you for your refusal.

RISK AND DISCOMFORT INVOLVED

The risk may include the potential for your discomfort during participation due to the fear associated with the prevailing socio-political environment in Zimbabwe. On this, I assure you that the findings will be used specifically for the academic purposes of this study, and that your confidentiality will be protected throughout to the effect that findings will not be directly related to you. There is also a risk that your participation will disrupt your work. To

minimize this, prior arrangements have been made and effort will also be made to ensure that the interview will take an hour as advised. Arrangements may also be made to re-schedule the interview if need be. Some of the questions we are going to ask you may make you feel uncomfortable, but you need not answer them if you don't want to.

BENEFITS AND/OR COMPENSATION

Your participation is voluntary. I do not promise or guarantee that you will receive any direct benefits from this study. However, findings will benefit you indirectly from Human Resource for Health Policy recommendations based No compensation or contribution towards your transport expenses will be given for your participation.

However, the results of the study will be reported back to you upon completion of this study. In the event that the questions asked cause emotional distress to you, then the researcher will refer you to a competent counsellor for counselling.

YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you or your treatment in any way.

ALTERNATIVE PROCEDURES OR TREATMENTS

The interview may be stopped at any point for your convenience and arrangements may be made to re-schedule or cancel it if need be.

CONFIDENTALITY

If you indicate willingness to participate in this study by signing this document, I plan to disclose findings to the Faculty of Health Sciences at the University of Pretoria, Medical Research Council of Zimbabwe and Epworth Local Board. Findings will be reported to the International Development Research Centre, African Population and Health Research Centre, Faculty of Health Sciences at the University of Pretoria, and Epworth Local Board. Research findings will also be made to the Ministry of Health and Child Care of Zimbabwe, Health Services Board of Zimbabwe, Department of Health in South Africa, South African National Aids Council, and the World Health Organization's Regional Office for Africa. Other ways

of reporting the research findings to have practical policy and action impacts will also be collaboratively sought in discussion with participants and stakeholders to be involved in this study. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your Permission. However, for purposes of examination, this information will be disclosed to the School of Health Systems and Public Health, Faculty of Health Sciences at the University of Pretoria.

ADDITIONAL COSTS

There are no costs for your participation. However, if there is a possibility of there being costs, these will be met by the lead researcher of this project.

IN THE EVENT OF INJURY

In the event of injury resulting from your participation in this study, treatment shall be offered by this study. In the event of injury, contact the lead researcher on 0718 177 337 who is available 24 hours per day to help attend to your injury.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with any of the stakeholders involved. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without consequences or penalties.

ADDITIONAL ELEMENTS

There are no consequences for your decision to withdraw from the research. This decision to withdraw may be made verbally. You may withdraw from the research if it interferes with your work, become ill or if for whatever reason it is not in your interest to participate, even when prior arrangements for your participation would have been made by way of booking for an appointment.

SIGNATURE PAGE

PROJECT TITLE

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

MRCZ/A/1941

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ _____

Name of Research Participant (please print) Date

_____ _____

Signature of Participant or legally authorized representative Time

_____

Relationship to the Participant

[the above two lines should appear on forms signed by legal representatives of the participant, for example the parents of a minor.]

_____	_____	_____
Name of Staff Obtaining Consent	Signature	Date
_____	_____	_____
Name of Witness (*if required)*	Signature	Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

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 (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Audio, Video Recording and Photography

Statement of Consent to be photographed, Audiotaped or Videotaped.

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to having my **photograph taken** **Yes** ☐ **No** ☐
- I agree to **being audio recorded** **Yes** ☐ **No** ☐
- I agree to having my **video recorded** **Yes** ☐ **No** ☐

[delete the options that are not appropriate for this study]

_____ _____ _____

Name of Participant (please print) Signature Date

INFORMED CONSENT FORM FOUR

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Health Sciences

School of Health Systems and Public Health

INFORMED CONSENT FORM FOR ADULT HUMAN RESOURCE FOR HEALTH PERSONNEL

[LOCAL HEALTH FACILITY HUMAN RESOURCE FOR HEALTH PERSONNEL]

PROJECT TITLE:

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

Principal Investigator:

Hope Taderera [Special Med MPH (UP), MPA (UZ)]

Contact Details:

+263 718 177 337

htaderera@gmail.com

Research Ethics Committee

Faculty of Health Sciences

University of Pretoria

+27 12 354 1330

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.

- Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient. The main goal of research studies is to gain knowledge that may help future patients.

- We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.

- You have the right to refuse to take part, or agree to take part now and change your mind later.

- Whatever you decide, it will not affect your regular care.

- Please read this consent form carefully. Ask any questions before you make a decision.

- Your participation is voluntary.

ETHICAL APPROVAL

Permission to carry out this study has been granted by the Ministry of Health and Child Care (MHCC); Health Services Board (HSB); Medical Research Council of Zimbabwe (MRCZ); the Provincial Medical Directorate of Mashonaland East; Seke Rural District Medical Directorate; the Epworth Local Board; Academic Advisory, and the Research Ethics Committees of the Faculty of Health Sciences, University of Pretoria, South Africa.

The research also complies with the ethical norms of bodies that protect the interests of research participants like you, for example the Medical Research Council and the Health Professions Council of South Africa and the Declaration of Helsinki (last updated October 2000) which gives guidelines to doctors doing research with people.

PURPOSE

You are being asked to participate in an academic study of the PhD in Public Health Programme that I am enrolled for at the above-mentioned institution. The aim of this study is to examine decision space and its impact in the implementation of human resource for health interventions in the context of semi formal/ peri-urban communities. Analysis will focus on the implementation of the Human Resource for Health Strategic Plan (2010-2014) of the 2009 Human Resources for Health Policy in Zimbabwe. You were selected to participate in this study because you are a policy maker. Other participants in this study include National

and Regional Level Policy Makers, Local Human Resource for Health Policy Maker from the Epworth Local Board; the Community Health Officer for Epworth; seven Human Resource for Health Managers at Facilities across Epworth; and 70 Adult Focus Group Discussion Participants to be drawn from Epworth.

NATURE

The aim of this study is to examine decision space and its impact in the implementation of the Human Resource for Health Policy in Epworth, Zimbabwe between 2009 and 2014. Decision Space Mapping Analysis will be used to examine data.

This study will contribute to the on-going research track activities of the Health Policy and Management of the School of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria. It will also contribute to the Human Resource for Health policy in Zimbabwe and beyond. You as a participant are a very important source of information on this topic.

PROCEDURE AND DURATION

If you decide to participate, you will undergo an interview in which I will ask some questions using a questionnaire. I also kindly ask to record our conversation so that l may be able to catch up on things that l may miss out on during our discussion. The interview will take about an hour of your time. A follow up interview may be held if need be. Participation may also involve photography of Human Resource for Health artifacts from your organization. The photos will be used for purposes of this study only. However, you also have the right to refuse to have these photos taken or to be recorded. There will be no consequence to you for your refusal

RISK AND DISCOMFORT INVOLVED

The risk may include the potential for your discomfort during participation due to the fear associated with the prevailing socio-political environment in Zimbabwe. On this, I assure you that the findings will be used specifically for the academic purposes of this study, and that your confidentiality will be protected throughout to the effect that findings will not be directly related to you. There is also a risk that your participation will disrupt your work. To minimize this, prior arrangements have been made and effort will also be made to ensure that

the interview will take an hour as advised. Arrangements may also be made to re-schedule the interview if need be. Some of the questions we are going to ask you may make you feel uncomfortable, but you need not answer them if you don't want to.

BENEFITS AND/OR COMPENSATION

Your participation is voluntary. I do not promise or guarantee that you will receive any direct benefits from this study. However, findings will benefit you indirectly from Human Resource for Health Policy recommendations based No compensation or contribution towards your transport expenses will be given for your participation.

However, the results of the study will be reported back to you upon completion of this study. In the event that the questions asked cause emotional distress to you, then the researcher will refer you to a competent counsellor for counselling.

YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you or your treatment in any way.

ALTERNATIVE PROCEDURES OR TREATMENTS

The interview may be stopped at any point for your convenience and arrangements may be made to re-schedule it if need be.

CONFIDENTALITY

If you indicate willingness to participate in this study by signing this document, I plan to disclose findings to the Faculty of Health Sciences at the University of Pretoria, Medical Research Council of Zimbabwe and Epworth Local Board. Findings will be reported to the International Development Research Centre, African Population and Health Research Centre, Faculty of Health Sciences at the University of Pretoria, and Epworth Local Board. Research findings will also be made to the Ministry of Health and Child Care of Zimbabwe, Health Services Board of Zimbabwe, Department of Health in South Africa, South African National Aids Council, and the World Health Organization's Regional Office for Africa. Other ways of reporting the research findings to have practical policy and action impacts will also be collaboratively sought in discussion with participants and stakeholders to be involved in this

study. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your Permission. However, for purposes of examination, this information will be disclosed to the School of Health Systems and Public Health, Faculty of Health Sciences at the University of Pretoria.

ADDITIONAL COSTS

There are no costs for your participation. However, if there is a possibility of there being costs, these will be met by the lead researcher of this project.

IN THE EVENT OF INJURY

In the event of injury resulting from your participation in this study, treatment shall be offered by this study. In the event of injury, contact the lead researcher on 0718 177 337 who is available 24 hours per day to help attend to your injury.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with any of the stakeholders involved. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without consequences or penalties.

ADDITIONAL ELEMENTS

There are no consequences for your decision to withdraw from the research. This decision to withdraw may be made verbally. You may withdraw from the research if it interferes with your work, become ill or if for whatever reason it is not in your interest to participate, even when prior arrangements for your participation would have been made by way of booking for an appointment.

SIGNATURE PAGE

PROJECT TITLE

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

MRCZ/A/1941

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ _____

Name of Research Participant (please print) Date

_____ _____

Signature of Participant or legally authorized representative Time

_____

Relationship to the Participant

[the above two lines should appear on forms signed by legal representatives of the participant, for example the parents of a minor.]

_____	_____	_____
Name of Staff Obtaining Consent	Signature	Date
_____	_____	_____
Name of Witness (*if required)*	Signature	Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

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 (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Audio, Video Recording and Photography

Statement of Consent to be photographed, Audiotaped or Videotaped.

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to having my **photograph taken** **Yes** ☐ **No** ☐
- I agree to **being audio recorded** **Yes** ☐ **No** ☐
- I agree to having my **video recorded** **Yes** ☐ **No** ☐

[delete the options that are not appropriate for this study]

_____ _____ _____

Name of Participant (please print) Signature Date

INFORMED CONSENT FORM FIVE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Health Sciences

School of Health Systems and Public Health

INFORMED CONSENT FORM FOR ADULT COMMUNITY MEMBERS

[LOCAL WARD COMMUNITY MEMBERS]

PROJECT TITLE:

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

Principal Investigator:

Hope Taderera [Special Med MPH (UP), MPA (UZ)]

Contact Details:

+263 718 177 337

htaderera@gmail.com

Research Ethics Committee

Faculty of Health Sciences

University of Pretoria

+27 12 354 1330

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.

- Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient. The main goal of research studies is to gain knowledge that may help future patients.

- We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.

- You have the right to refuse to take part, or agree to take part now and change your mind later.

- Whatever you decide, it will not affect your regular care.

- Please read this consent form carefully. Ask any questions before you make a decision.

- Your participation is voluntary.

ETHICAL APPROVAL

Permission to carry out this study has been granted by the Ministry of Health and Child Care (MHCC); Health Services Board (HSB); Medical Research Council of Zimbabwe (MRCZ); the Provincial Medical Directorate of Mashonaland East; Seke Rural District Medical Directorate; the Epworth Local Board; Academic Advisory, and the Research Ethics Committees of the Faculty of Health Sciences, University of Pretoria, South Africa.

The research also complies with the ethical norms of bodies that protect the interests of research participants like you, for example the Medical Research Council and the Health Professions Council of South Africa and the Declaration of Helsinki (last updated October 2000) which gives guidelines to doctors doing research with people.

PURPOSE

You are being asked to participate in an academic study of the PhD in Public Health Programme that I am enrolled for at the above-mentioned institution. The aim of this study is to examine decision space and its impact in the implementation of human resource for health interventions in the context of semi formal/ peri-urban communities. Analysis will focus on the implementation of the Human Resource for Health Strategic Plan (2010-2014) of the 2009 Human Resources for Health Policy in Zimbabwe. You were selected to participate in this study because you are a policy maker. Other participants in this study include National and Regional Level Policy Makers, Local Human Resource for Health Policy Maker from the Epworth Local Board; the Community Health Officer for Epworth; seven Human Resource

for Health Managers at Facilities across Epworth; a sample of 146 Nurses from health facilities across Epworth; and six District Health Cadres who include the Environmental Health Officer, Pharmacists, Physiotherapists, Nutritionists, Laboratory Technicians, and Rehabilitation Technicians.

NATURE

The aim of this study is to examine decision space and its impact in the implementation of the Human Resource for Health Policy in Epworth, Zimbabwe between 2009 and 2014. Decision Space Mapping Analysis will be used to examine data.

This study will contribute to the on-going research track activities of the Health Policy and Management of the School of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria. It will also contribute to the Human Resource for Health policy in Zimbabwe and beyond. You as a participant are a very important source of information on this topic.

PROCEDURE AND DURATION

If you decide to participate, you will participate in a Focus Group Discussion in which I will ask some questions for discussion using an interview guide. I also kindly ask to record our conversation so that l may be able to catch up on things that l may miss out on during our discussion. The interview will take about an hour of your time. A follow up interview may be held if need be. Participation may also involve photography of Human Resource for Health artifacts from your organization. The photos will be used for purposes of this study only. However, you also have the right to refuse to have these photos taken or to be recorded. There will be no consequence to you for your refusal.

RISK AND DISCOMFORT INVOLVED

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the interview will take an hour as advised. Arrangements may also be made to re-schedule the interview if need be. Some of the questions we are going to ask you may make you feel uncomfortable, but you need not answer them if you don't want to.

BENEFITS AND/OR COMPENSATION

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However, the results of the study will be reported back to you upon completion of this study. In the event that the questions asked cause emotional distress to you, then the researcher will refer you to a competent counsellor for counselling.

YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you or your treatment in any way.

ALTERNATIVE PROCEDURES OR TREATMENTS

The interview may be stopped at any point for your convenience and arrangements may be made to re-schedule or cancel it if need be.

CONFIDENTALITY

If you indicate willingness to participate in this study by signing this document, I plan to disclose findings to the Faculty of Health Sciences at the University of Pretoria, Medical Research Council of Zimbabwe and Epworth Local Board. Findings will be reported to the International Development Research Centre, African Population and Health Research Centre, Faculty of Health Sciences at the University of Pretoria, and Epworth Local Board. Research findings will also be made to the Ministry of Health and Child Care of Zimbabwe, Health Services Board of Zimbabwe, Department of Health in South Africa, South African National Aids Council, and the World Health Organization's Regional Office for Africa. Other ways of reporting the research findings to have practical policy and action impacts will also be collaboratively sought in discussion with participants and stakeholders to be involved in this

study. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your Permission. However, for purposes of examination, this information will be disclosed to the School of Health Systems and Public Health, Faculty of Health Sciences at the University of Pretoria.

ADDITIONAL COSTS

There are no costs for your participation. However, if there is a possibility of there being costs, these will be met by the lead researcher of this project.

IN THE EVENT OF INJURY

In the event of injury resulting from your participation in this study, treatment shall be offered by this study. In the event of injury, contact the lead researcher on 0718 177 337 who is available 24 hours per day to help attend to your injury.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with any of the stakeholders involved. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without consequences or penalties.

ADDITIONAL ELEMENTS

There are no consequences for your decision to withdraw from the research. This decision to withdraw may be made verbally. You may withdraw from the research if it interferes with your work, become ill or if for whatever reason it is not in your interest to participate, even when prior arrangements for your participation would have been made by way of booking for an appointment.

SIGNATURE PAGE

PROJECT TITLE

Do National Human Resource for Health Policy interventions impact successfully on Local Human Resource for Health Systems: a Case Study of Epworth, Zimbabwe

MRCZ/A/1941

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ _____

Name of Research Participant (please print) Date

_____ _____

Signature of Participant or legally authorized representative Time

_____

Relationship to the Participant

[the above two lines should appear on forms signed by legal representatives of the participant, for example the parents of a minor.]

_____	_____	_____
Name of Staff Obtaining Consent	Signature	Date
_____	_____	_____
Name of Witness (*if required)*	Signature	Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

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 (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Audio, Video Recording and Photography

Statement of Consent to be photographed, Audiotaped or Videotaped.

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to having my **photograph taken** **Yes** ☐ **No** ☐
- I agree to **being audio recorded** **Yes** ☐ **No** ☐
- I agree to having my **video recorded** **Yes** ☐ **No** ☐

[delete the options that are not appropriate for this study]

_____ _____ _____

Name of Participant (please print) Signature Date

AUTHORIZATION AND ETHICAL CLEARANCE LETTERS

Telephone: +263-4-730011
Telegraphic Address: "MEDICUS", Harare
Fax: +263-4-729154/793634 (702293 FHP)

ZIMBABWE

Reference: A/12/101
Ministry of Health and Child Care
P O Box CY1122
Causeway
HARARE

11 December 2014

Mr Hope Bernard Taderera
Department of Political and Administrative Studies
University of Zimbabwe
P.O Box MP 167
Mount Pleasant
Harare

APPLICATION FOR PERMISSION TO DO RESEARCH ENTITLED "DO NATIONAL HUMAN RESOURCE FOR HEALTH POLICY INTERVENTIONS IMPACT SUCCESSFULLY ON LOCAL HUMAN RESOURCE FOR HEALTH SYSTEMS: A CASE STUDY OF EPWORTH"

Reference is made to your application letter dated 11 November 2014 regarding the above subject.

The Ministry of Health and Child Care approves your application to do collect data in the Health Sector, Human Resources for Health organisations in Harare and health establishments in Epworth in partial fulfilment of your PhD in Public Health studies on a topic entitled, "Do national human resources for health policy interventions impact successfully on local human resource for health systems: a case study of Epworth Zimbabwe".

SECRETARY FOR HEALTH & CHILD CARE
(01) SECRETARY OFFICE (01)
15 DEC 2014
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

Brigadier General (Dr.) G. Gwinji
SECRETARY FOR HEALTH AND CHILD CARE

6th & 7th Floor Kopje Plaza Building
Cnr. J. Moyo/Kaguvi Street, Harare.
Telephone: +263 4 759970-4
Direct Line: +263 4 759 979
Fax: +263 4 772 154/775581
E-mail: infor@hsb.co.zw/infor@hsb.co.zw
Website: www.hsb.co.zw

HEALTH SERVICE BOARD
"Pulling Together For Health"

Ref: HR/SE
Health Service Board
Private Bag A6104
Avondale
Harare
Zimbabwe
hr@hsb.co.zw

10 February 2015

Mr Hope Bernard Taderera
Department of Political and Administrative Studies
University of Zimbabwe
P.O Box MP 111167
Mount Pleasant
Harare

Dear Sir

RE: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH ENTITILED "DO NATIONAL HUMAN RESOURCE FOR HEALTH POLICY INTERVENTIONS IMPACT SUCCESSIFULLY ON LOCAL HUMAN RESOURCE FOR HEALTH SYSTEMS: A CASE STUDY OF EPWORTH

Reference is made to your minute dated 27 December 2014.

It is noted that you are requesting the Health Service Board for permission and assistance to enable you to carry out a research.

Please be advised that the Board on 6 February 2015 approved your request to carry out your research and interview the necessary officers in the sector.

pp Machakata
R.R Kaseke (Ms)
Executive Director
HEALTH SERVICE BOARD

HEALTH SERVICE BOARD
EXECUTIVE DIRECTOR
17 FEB 2015
P. BAG A 6104, AVONDALE
HARARE, ZIMBABWE

Board: *Dr O. L. Mbengeranwa (Executive Chairman), Dr E. Xaba (Vice Chairprson), Mrs T. J. Watungwa, Mrs E. Y. Mangwende, Mr S. Gula-Ndebele, Mrs R.P Smith*

FILE

Telephone: 24207/8, 24571

Telegraphic Address:
"PROVMED, MARONDERA"
Fax: 23967

ZIMBABWE

Reference:

MINISTRY OF HEALTH AND
CHILD CARE
PROVINCIAL MEDICAL DIRECTOR
(MASHONALAND EAST)
P.O.BOX 10
MARONDERA
ZIMBABWE

9th January 2015

The District Medical Officer
SEKE DISTRICT

RE: AUTHORISATION TO CARRY OUT ACADEMIC STUDY IN EPWORTH : "DO NATIONAL HUMAN RESOURCE FOR HEALTH POLICY INTERVENTIONS IMPACT SUCCESSFULLY ON LOCAL HUMAN RESOURCE FOR HEALTH SYSTEMS"

The above subject refers.

Permission has been granted for Mr Hope B. Taderera to carry out the above-mentioned study in your district.

May you please assist him.

Kind regards

MINISTRY OF HEALTH
P.M.D. MASHONALAND EAST
2015 -01- 09
P.O. BOX 10
MARONDERA

Dr A. Kuretu
ACTING PROVINCIAL MEDICAL DIRECTOR – MASHONALAND EAST

/sk

Telephone: +2638644080180
Fax 065-506

Reference: 7/1/26/2015

ZIMBABWE

MINISTRY OF HEALTH AND CHILD CARE
District Medical Office
Seke District
P. Bag 818
SEKE

15th July 2015

The Sister-In-Charge, Epworth Polyclinic

The Sister-In-Charge, Epworth Overspill Clinic

The Sister-In-Charge, Epworth Mission

Dear Madam

APPROVAL TO CARRY OUT STUDY: BERNARD HOPE TADERERA

The above matter refers.

The Office of the District Medical Officer has approved the above named cadre to carry out a study at your clinic.

Your cooperation in this matter is greatly appreciated.

Yours sincerely

DR. B MADEDE
DISTRICT MEDICAL OFFICER – SEKE

/rnm

MIN. OF HEALTH & CHILD CARE
DISTRICT MEDICAL OFFICER
SEKE DISTRICT
15 JUL 2015
P. BAG 818. SEKE
ZIMBABWE

EPWORTH LOCAL BOARD

1038 Chiremba Road
P. O. BOX EP180
EPWORTH

Telephone :263 4 2936393-6
:263 4 577445/9
Email :elb@africaonline.co.zw

ALL CORRESPONDENCE SHOULD BE ADDRESSED TO THE SECRETARY

ELB REF: YOUR REF:

06 January 2015

Mr B Taderera
Department of Political and Administrative Studies
University of Zimbabwe
P.O Box MP167
Mount Pleasant
Harare

Dear Sir

REF: REQUEST FOR PERMISSION TO CARRY OUT AN ACADEMIC STUDY

The above refers:

Receipt of your application for the above is hereby acknowledged. We would like to inform you that as council, we have no objections to your request. However, you are advised to first seek clearance from the District Medical Officer in Seke.

Thank you

Yours faithfully

K Muhomba
SECRETARY
EPWORTH LOCAL BOARD

EPWORTH LOCAL BOARD
REGISTRY
- 6 JAN 2015
P.O. BOX EP180
EPWORTH
TEL: +263-4-2936393-6/577445/9

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/A/1941 **25 June 2015**

Hope Bernard Taderera
University of Pretoria
Faculty of Health Sciences and Public Health
Private Bag X323
Pretoria

RE: Do national human resources for health interventions impact successfully on local human resources for health systems: a case study of Epworth, Zimbabwe

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

a) Protocol
b) Informed Consent Forms (English and Shona)
c) Data collection Tool (English and Shona)

- **APPROVAL NUMBER : MRCZ/A/1941**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING : Full Board**
- **EFFECTIVE APPROVAL DATE : 25 June 2015**
- **EXPIRATION DATE : 24 June 2016**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

.....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2015 -06- 25
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

30/10/2014

Approval Certificate
New Application

Ethics Reference No: 413/2014

Title: Do national human resources for health interventions impact successfully on local human resources for health systems: a case study of Epworth, Zimbabwe.

Dear Mr Hope Taderera

The **New Application** as supported by documents specified in your cover letter for your research received on the 23/09/2014, was Provisional approved by the Faculty of Health Sciences Research Ethics Committee on the 29/10/2014.

Please note the following about your ethics approval:
- Ethics Approval is valid for 2 years.
- Please remember to use your protocol number (**413/2014**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:
- Provisionally approved, pending permissions by Zimbabwe's authorities.

We wish you the best with your research.

Yours sincerely

*** Kindly collect your original signed approval certificate from our offices, Faculty of Health Sciences. Research Ethics Committee, H W Snyman South Building, Room 2.33 / 2.34.*

Dr R Sommers; MBChB; MMed (Int); MPharMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 354 1677 🖷 0866516047 deepeka.behari@up.ac.za http://www.healthethics-up.co.za
✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

MEDECINS SANS FRONTIERES

MSF OCA
90 Lytton Road,
Workington, Harare
Zimbabwe

+263 (0) 712 456 537
+263 (0) 712 456 530
+263 (0) 868 300 0828
+263 (0) 868 300 0889
zimbabwe-admin@oca.msf.org
http://www.msf.org

19 August 2015

Att: Mr Hope Bernard Taderera
Department of Political and Administrative Studies
P O Box MP 167
Mount Pleasant
Harare

Dear Mr Taderera

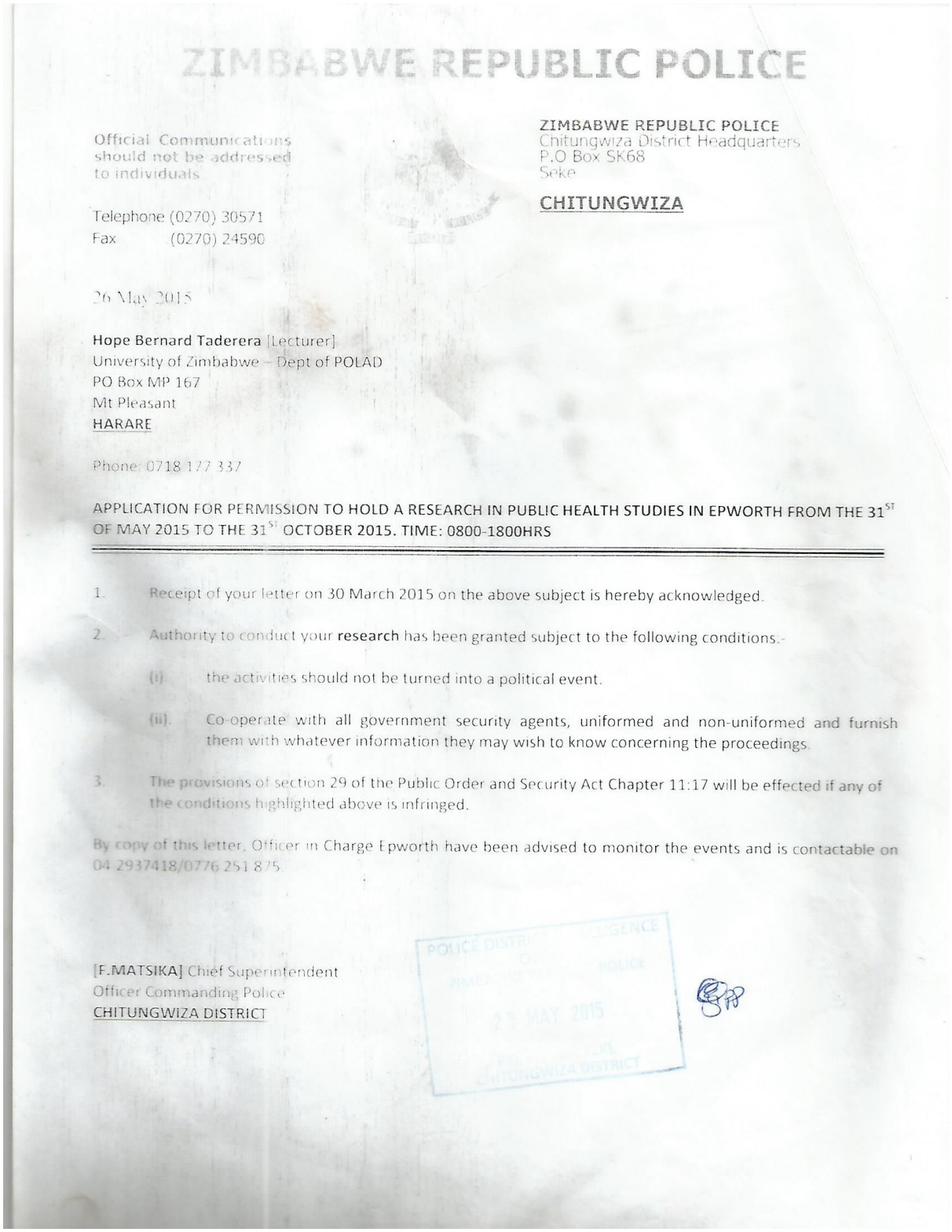
Re: Request for Authorization and Assistance in PhD in Public Health Research.

We acknowledge receipt of copy of your PhD proposal as well as your executive summary which we forwarded to our Head Quarters for consideration.

We are pleased to inform you that your request to interview MSF staff at the Epworth Polyclinic has been granted.

Yours faithfully

Abi Kebra Belaye
Head of Mission
Medecins Sans Frontieres – Holland
90 Lyton Rd, Workington
Mobile: 0712 447 100
E-mail: Zimbabwe-hom@oca.msf.org



ZIMBABWE REPUBLIC POLICE

Official Communications should not be addressed to individuals

Telephone (0270) 30571
Fax (0270) 24590

ZIMBABWE REPUBLIC POLICE
Chitungwiza District Headquarters
P.O Box SK68
Seke

CHITUNGWIZA

26 May 2015

Hope Bernard Taderera [Lecturer]
University of Zimbabwe – Dept of POLAD
PO Box MP 167
Mt Pleasant
HARARE

Phone: 0718 177 337

APPLICATION FOR PERMISSION TO HOLD A RESEARCH IN PUBLIC HEALTH STUDIES IN EPWORTH FROM THE 31ST OF MAY 2015 TO THE 31ST OCTOBER 2015. TIME: 0800-1800HRS

1. Receipt of your letter on 30 March 2015 on the above subject is hereby acknowledged.

2. Authority to conduct your research has been granted subject to the following conditions.-

(i) the activities should not be turned into a political event.

(ii) Co-operate with all government security agents, uniformed and non-uniformed and furnish them with whatever information they may wish to know concerning the proceedings.

3. The provisions of section 29 of the Public Order and Security Act Chapter 11:17 will be effected if any of the conditions highlighted above is infringed.

By copy of this letter, Officer in Charge Epworth have been advised to monitor the events and is contactable on 04 2937418/0776 251 875.

[F.MATSIKA] Chief Superintendent
Officer Commanding Police
CHITUNGWIZA DISTRICT

POLICE DISTRICT INTELLIGENCE OFFICE ZIMBABWE POLICE 25 MAY 2015 CHITUNGWIZA DISTRICT

PROJECT SUMMARY

The study determined how national human resource for health policy interventions of 2009 to 2014 impacted the local human resource for health system in Epworth, a peri-urban community in south-east Harare, Zimbabwe. The approach of study was based on the Decision Space Approach developed by Dr. Thomas Bossert of the Harvard School of Public Health (HSPH). The aim was to contribute towards the health system reform agenda through human resource for health reform. This came out of the realization that whilst human resources for health are a critical of health systems, the global health workforce crisis is a challenge undermining health system reform throughout the world. This challenge was revealed through the World Health Report of 2006 in which a critical shortage of healthcare workers particularly in sub-Saharan Africa was identified as a key challenge. This revelation led to the establishment of the Global Health Workforce Alliance, that organized the First Global Forum on Human Resources for Health in 2008 from which the Kampala Declaration and Agenda for Global Action towards human resource for health reform. However, whilst policy interventions have been made towards human resource for health reform throughout the world since, available literature does not provide a detailed narrative on how national human resource for health policy interventions impact local human resource for health systems in peri-urban communities. Against this background, the Decision Space Approach was used to determine decision space between the principal (Ministry of Health) and the agent (Epworth peri-urban community), innovation (decisions made), and change (policy outcomes/impact). The research design was a case study in which qualitative and quantitative methods were used. Data collected at the principal level, through key-informant interviews and policy review generated a Human Resource for Health Policy Decision Space Mapping Analysis Conceptual Tool. It consisted of six policy result areas around which data was then collected at the agent level through in-depth interviews, sample interviews, focus group discussions and a documentary search. The conceptual tool was also used to facilitate analysis using the Decision Space Approach. It was established that intervention by the Ministry of Health, in which narrow decision space was retained on training and development, strategic partnerships, labour relations, safety, protection, and information and research was undermined by capacity constraints. The local board and mission who enjoyed moderate decision space engaged in functional innovation on human resource planning, budgeting, deployment, and retention, and performance management were also constrained. The local private sector enjoyed wide decision space on all policy functions, but their contribution was undermined by a narrow revenue base. Conclusively, ministerial

intervention, collaboration and decision space between actors at the principal and agent levels was both necessary and inevitable as it helped revive the local human resource for health system. It was recommended that decision space of 2009 to 2014 be reinforced and sustained until healthcare worker policy outcomes are realized. In addition, the conceptual tool is recommended for use with adaptive modification in similar studies around the world towards the health system reform agenda.

KEY WORDS: Decision Space Approach; Human Resource for Health; Reform; Peri-urban area; Epworth; Zimbabwe