Chapter Five

# Nursing the Health System: The Migration of Health Professionals from Zimbabwe

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The brain drain of health professionals from Zimbabwe has had a crippling effect on the country's public health system.[1] The migration of doctors and nurses has been driven by a marked deterioration in working conditions and job prospects at home and unprecedented global opportunities for professional mobility. The poor salaries paid to local professionals compared to those in developed countries have hastened the exodus. By 2000, Zimbabwe had become a leading source country for health professionals, with 51 percent of locally-trained doctors and 25 percent of locally-trained nurses practising abroad.[2] The growing migration of nurses has had a particularly negative impact on primary patient care. Nurses form the backbone of any health service delivery and their out-migration exacerbates the primary health care crisis in sending countries like Zimbabwe.

In Zimbabwe, the quality of care declined markedly as nurses left the country in growing numbers.[3] Patient waiting times increased and the nurses that remained had to cope with heavier workloads. Nurses working in rural areas have been forced into an expanding role, taking on the responsibilities of pharmacist, doctor, physiotherapist and so forth.[4] Heavy workloads, besides being a manifestation of poor staffing levels, have been an additional motivation to migrate. Nurse migration leads to the appointment of

replacement workers in positions for which they are not trained. Other negative impacts include heavy workloads resulting in poor service provision to the public and the loss of financial investments made in educating the nurses.[5] The stress of handling HIV and AIDS-related deaths on a daily basis also takes its toll on the nurses who remain.[6]

This chapter examines the causes, dimensions and impacts of nurse migration from Zimbabwe during the period of the late 1990s and early 2000s, drawing on research conducted by the author for the World Health Organization. The research sought to examine the magnitude of, and trends in, the migration of nurses and midwives from the country, establish the effects of the migration on the country's quality of healthcare, identify the causes of migration, and recommend measures for reducing out-migration. All of the evidence suggests that the trends in nurse migration identified in this period have intensified since the research was conducted.

## TRENDS IN NURSE MIGRATION

Two main survey instruments were used to collect data for this study. The first aimed to collect information on staffing patterns and workloads at health institutions. Stratified random sampling was employed in selecting healthcare facilities. Seven of Zimbabwe's 10 provinces were randomly selected. In each of these provinces, the main provincial town or city was chosen together with one district health institution and one health centre. In addition, two schools of Nursing and Midwifery were selected; these are located at Harare and Mpilo Central Hospitals. A questionnaire was distributed to each of the health institutions for completion by the hospital superintendent. Only 10 of the 21 health institutions provided information on both staffing patterns and the workload of nursing professionals.

The second research instrument was designed to collect information from individual nursing professionals on a wide range of issues including general working conditions and migration intentions. The individual nurses were drawn from the selected health institutions using stratified random sampling. The number of nurses from each health institution was proportional to the total number employed there. One hundred and fifty-seven questionnaires were administered (Table 5.1). The vast majority of the respondents were nurses (87 percent). The rest were midwives. Both had been trained at nurse training centres scattered throughout the country and most held diploma qualifications.

Only 3 percent were holders of a Bachelor's degree qualification and 1 percent a Master's degree. Twenty percent of the respondents were male, and 80 percent were female showing the dominance of women in the nursing profession in Zimbabwe. The majority of the respondents were married (68 percent) while 21 percent were single, 6 percent widowed and 5 percent divorced. Only 31 percent of the sample were younger than 30. In other words, the majority of those surveyed were experienced professionals with strong family ties to Zimbabwe.

Table 5.1: Profile of Nurses

| | % |
|---|---|
| Sex | |
| Male | 20 |
| Female | 80 |
| Marital Status | |
| Married | 68 |
| Divorced | 5 |
| Single | 21 |
| Widowed | 6 |
| Age Group | |
| 20 years and below | 3 |
| 21-30 | 28 |
| 31-40 | 34 |
| 41-50 | 17 |
| 51-60 | 6 |
| No Response | 12 |
| N = 157 | |

The large-scale movement of Zimbabwean nurses out of the country is a relatively recent phenomenon. Until the early 1990s, Zimbabwe's economy was performing well and the salaries of nurses were comparatively decent. However, the introduction of the structural adjustment programme (SAP) in 1991 at the behest of the IMF and World Bank resulted in deteriorating conditions in the health sector. Faced with rising inflation and declining salaries in real terms, nurses initially adopted a combative approach,

engaging in strike action in an attempt to press the government to give them living wages and improve their conditions of service. However, high inflation quickly eroded any wage gains made by the nurses.

The government responded by introducing legislation that made it illegal for health professionals, as providers of essential services, to engage in strike action. Living conditions deteriorated further in the late 1990s as donor support from Western nations dried up after the Mugabe government embarked on its controversial land reform programme. Political repression and persecution also grew as the regime's rule came under challenge for the first time since independence. Unable to eke out a decent living, nurses abandoned confrontation and "voted with their feet" by migrating to other countries.[7] According to one study, nurses were "not interested in political confrontations and struggles which might derail them from focusing on the well-being of their households. By leaving they condemned the political and economic present as inadequate for meeting their needs."[8]

Table 5.2: Distribution of Zimbabwe-Trained Nurses, 2005

| Location | No. | % of Total | % of those Abroad |
|---|---|---|---|
| Domestic (i.e. in Zimbabwe) | 11,640 | 75.8 | - |
| UK | 2,834 | 18.4 | 76.1 |
| USA | 440 | 2.9 | 11.8 |
| Australia | 219 | 1.4 | 5.9 |
| South Africa | 178 | 1.2 | 4.8 |
| Canada | 35 | 0.2 | 0.9 |
| Portugal | 14 | 0.1 | 0.4 |
| Spain | 3 | - | 0.1 |
| Total Abroad | 3,723 | 24.2 | 100 |
| Total | 15,363 | 100 | 100 |

Source: M. Clemens and G. Petterson, *A New Database for Health Professional Emigration from Africa* (Washington D.C: Centre for Global Development, 2005).

Most of those who initially migrated were more experienced nurses with skills that were marketable abroad, leaving behind junior and less-experienced staff. The early

wave went to South Africa, but the post-SAP era saw more Zimbabwean nurses migrating to Western countries (Table 5.2). The change in destination to countries outside the African continent is explained by the shortages of registered nurses in many developed countries.[9] These countries are faced with an ageing population and they need to care for an increasing number of elderly people.[10] There has also been a reduction in the number of people enrolling in nursing programmes in developed countries, creating severe nursing shortages. In addition, some countries, such as Canada, have experienced their own nurse "brain drain" to the United States.

Western countries have sought to solve their nursing shortages by aggressively recruiting professionals from developing countries such as Zimbabwe. Independent and government-supported recruitment and relocation agencies act as middlemen who initiate contact with prospective employers and manage the subsequent transfer of the professionals to the new destination.[11] Nurse migration has left most of Zimbabwe's health institutions with a skeleton staff struggling to cope with increased workloads and growing demands on their expertise.

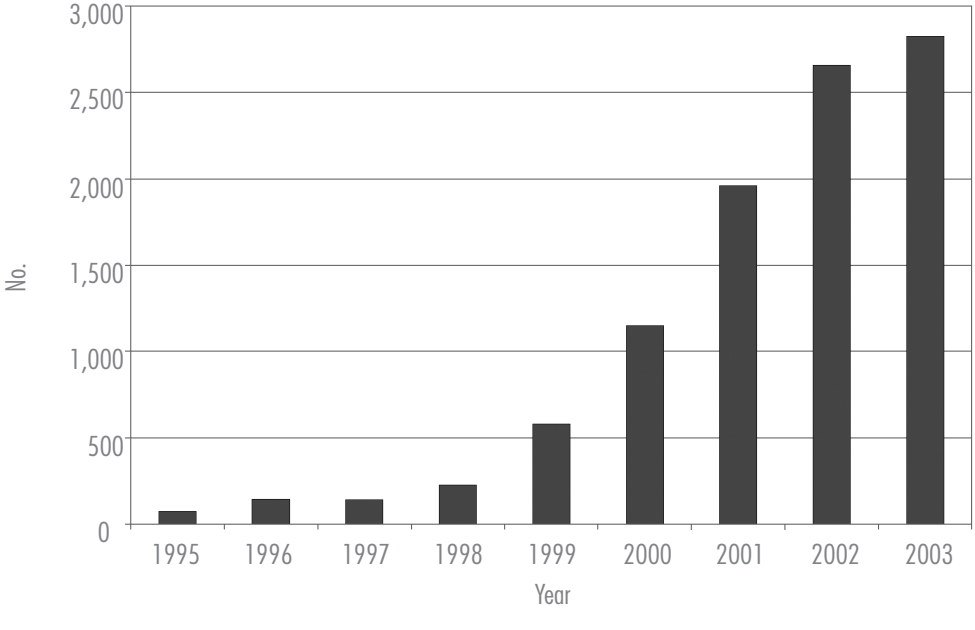


Figure 5.1: Zimbabwean Health Professionals in the UK, 1995-2003

The United Kingdom became the leading destination for nurses and other health professionals from Zimbabwe in the late 1990s. The number of Zimbabwean health professionals in the United Kingdom increased dramatically as political and economic conditions in Zimbabwe deteriorated (Figure 5.1). From a mere 76 health professionals migrating to the UK from Zimbabwe in 1995, the figure increased to 2,825 in 2003. Nurses comprised the majority of these professionals. For instance, of the 2,825 work permits offered to Zimbabwean health professionals in 2002-03, 2,346 (83%) went to nurses.[12] In 2003, Zimbabwe was the UK's fourth largest supplier of overseas nurses, after the Philippines, India and South Africa.

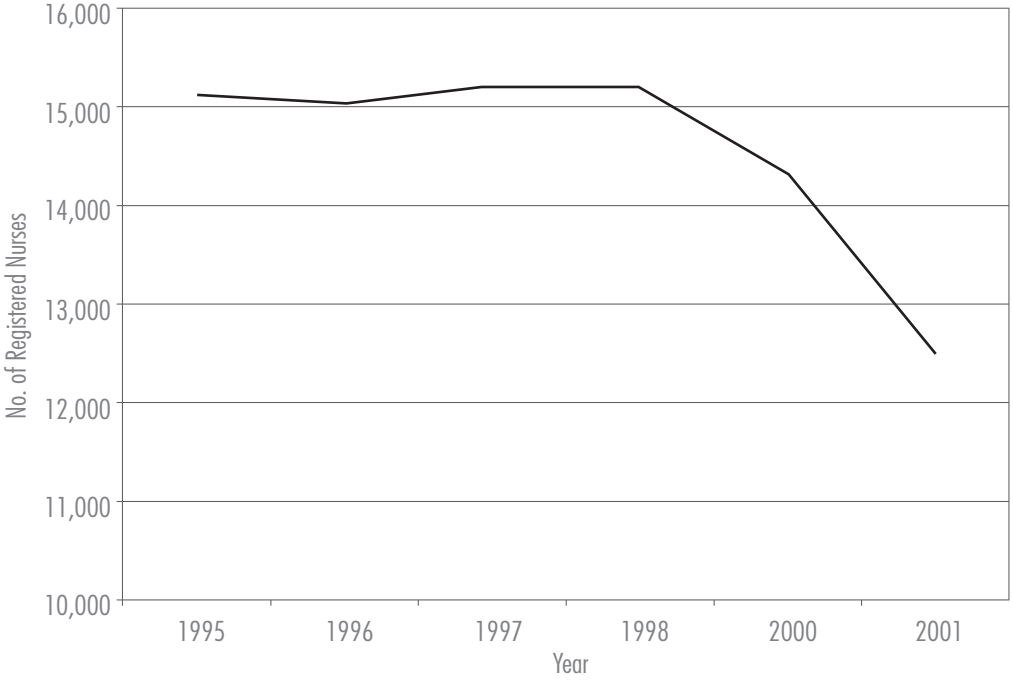


Figure 5.2: Registered Nurses in Zimbabwe, 1995-2001[15]

There were two distinct channels of nurse migration from Zimbabwe to the UK in the late 1990s. Some nurses moved through recruitment agencies, which also covered relocation expenses. Others moved as temporary visitors or "political refugees." The latter often ended up in non-nursing jobs or were employed in nursing homes that did not require them to register with the Nursing and Midwifery Council (NMC).

The exact magnitude of nurse migration from Zimbabwe is difficult to establish because of a lack of reliable data. Zimbabwe's Ministry of Health and Child Welfare (MoHCW) has no proper mechanisms to monitor the loss of professionals through migration, death or retirement. In the absence of proper statistics, an analysis of trends in registration figures provides useful insights on the magnitude of nurse migration from Zimbabwe. Data from the Central Statistical Office (CSO) shows that the number of registered nursing professionals available in the country was stable up to the late 1990s, when a significant decline was experienced. For instance, while there were 15,476 Registered Nurses (RNs) in Zimbabwe in 1998, only 12,477 remained by December 2001 (Figure 5.2).[14]

While there were some marginal increases in nursing categories such as midwives and psychiatric nurses, in other categories dramatic declines were recorded (Table 5.3). For instance, though there were 5,946 State Certified Nurses in 1997, by 2000 only 4,101 remained (a decline of 31 percent). The same trend can be observed for other categories such as State Certified Maternity Nurses and Paediatric Nurses, where net losses of 17 percent and 9 percent respectively were recorded.

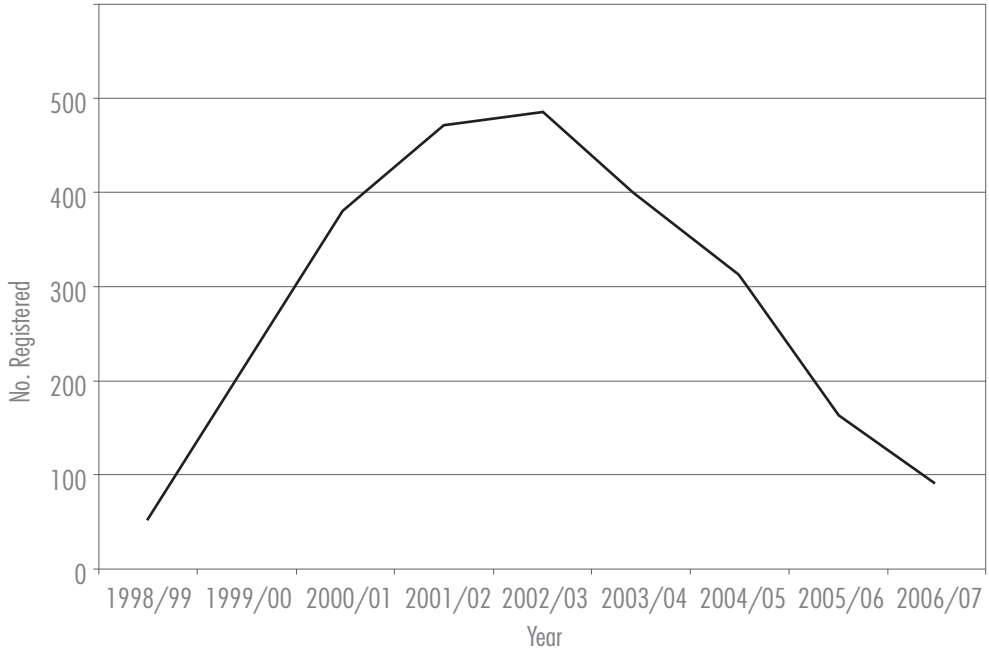


Figure 5.3: Zimbabwean Nurses Registered in the United Kingdom, 1998-2007[16]

Table 5.3: Registered Nurses, 1997-2000

| | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|
| Midwives | 3,656 | 3,840 | 4,264 | 4,250 |
| Psychiatric Nurses | 496 | 525 | 550 | 547 |
| State Certified Nurses | 5,946 | 5,927 | 4,773 | 4,101 |
| State Certified Maternity Nurses | 3,912 | 3,922 | 3,572 | 3,257 |
| Paediatric Nurses | 22 | 23 | 20 | 20 |

Source: Central Statistical Office (CSO), *Zimbabwe: Facts and Figures 2001/2002* (Harare, 2003).

The loss of nurses and midwives from Zimbabwe's health sector was reflected in a corresponding increase in the number of Zimbabwean-trained nurses in the UK. For instance, while 52 nurses were registered by the NMC in 1998-99, as many as 485 were on the register in 2002-03 (Figure 5.3). The actual figure was much higher, especially given the fact that some Zimbabwean-trained nurses are employed in other jobs where they are not required to register with the NMC. Between 2003 and 2007, the number of nurses registered fell to under 100.

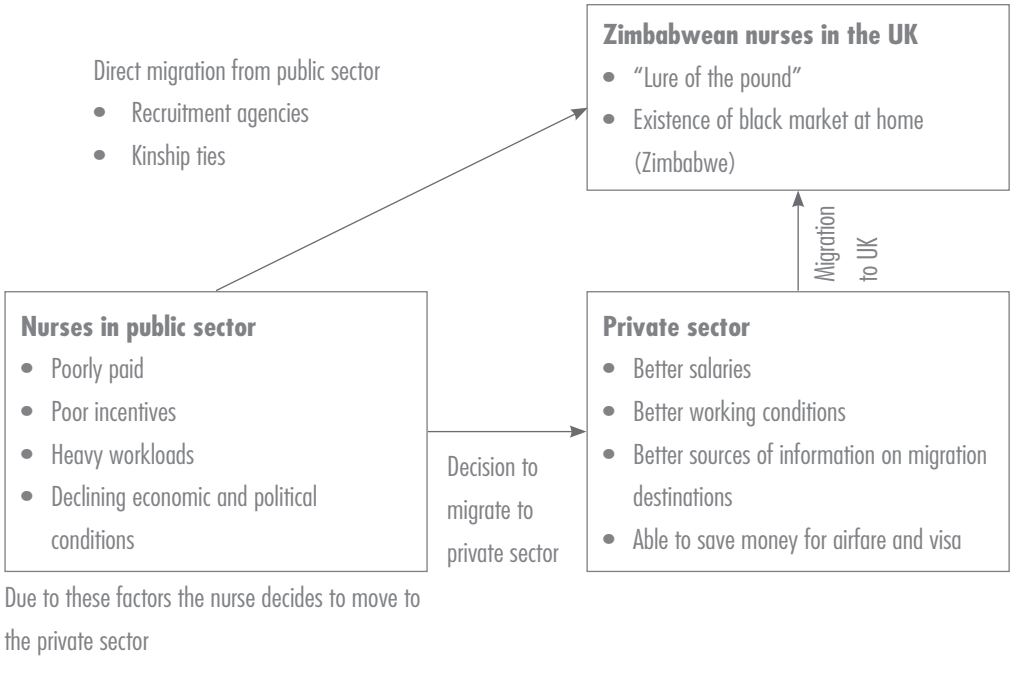


Figure 5.4: The Stepwise Migration of Zimbabwean Nurse Professionals

The shortage of nurses in Zimbabwe's health sector became more severe in public health institutions than in privately-run ones. In fact, a considerable number of nurses in Zimbabwe moved to the private sector which offered better remuneration and other conditions of service. In 1997, the public sector employed only 7,923 nurses out of a total requirement of 14,251 (or 56 percent), when the country had 16,407 RNs.[17] The privately-run health institutions thus employed 8,484 (or 51 percent) of all the RNs in the country, mostly in the urban areas.

The survey found that there was considerable stepwise migration in the behaviour of Zimbabwean nurses (Figure 5.4). In stepwise migration, a horizontal move is undertaken with the intention of assisting in a vertical or outward movement. In the case of Zimbabwean nurses, the "sideways" internal move to the private sector meant better salaries and increased opportunities to migrate to an overseas destination. Nurses initially moved to the private sector to enable them to save the necessary airfares, which eventually facilitated their move abroad. Besides being paid better, nurses employed in the private sector had better access to information due to their mainly urban location. When the nurses moved to the private sector, they thus increased their chances of moving abroad.

Not all nurses were involved in stepwise migration. In some cases, nurses migrated directly from the public sector to the UK. Friends and relatives residing abroad played a facilitating role by purchasing the air ticket for the prospective migrant and hosting them on arrival. In some cases, nurses employed in rural areas with good information networks also moved directly to an international destination. This is consistent with other findings that it is no longer necessary for international migration to have a national prologue, that is, the preliminary transfer to urban areas that was the classic launching pad for international migration until a few years ago.[18]

## IMPACTS OF NURSE MIGRATION

The public sector is the principal provider of healthcare in most African countries, including Zimbabwe. Information from the MoHCW on the staffing situation in the country's public health institutions showed a general decline in nurse employment in the 1990s (Figure 5.5). The number of nurses employed in the public health sector fell by nearly 20 percent, from 8,662 in 1996 to 7,007 in 1999. This decline occurred at a time when the country's training institutions produced 1,370 new nurses. While some nurses might have left the

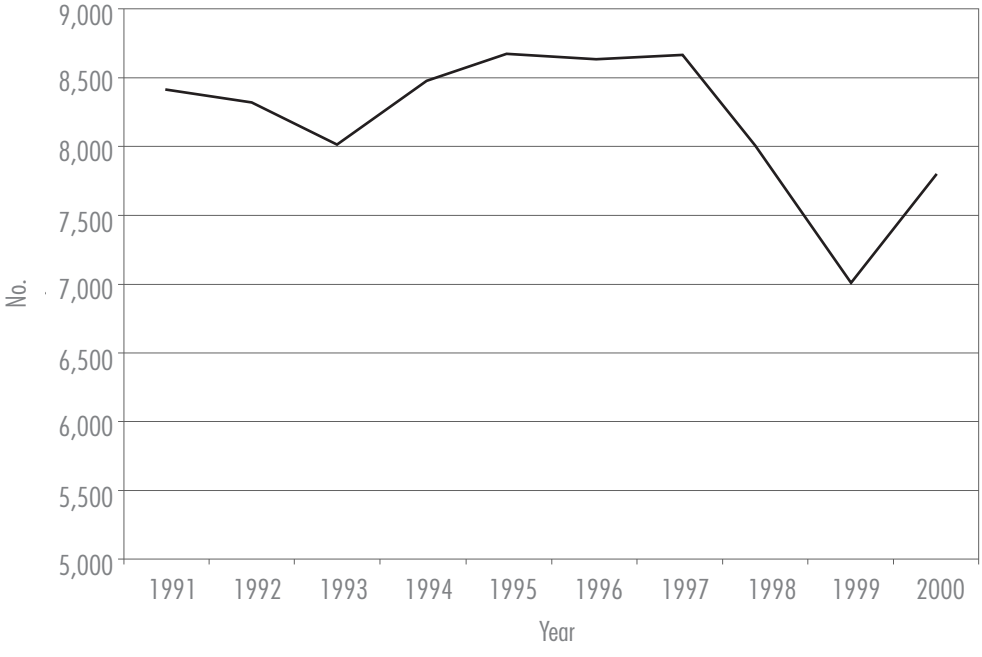


Figure 5.5: Number of Nurses in the Public Health Sector, 1991-2000

public sector through attrition (such as retirement and death), or moved to the private sector or left nursing altogether, a significant part of the decline is attributable to out-migration.

The MoHCW's nursing staff requirements for 1997 stood at 14,251, but only 56 percent of the posts were filled. Evidence that movement from the public to the private sector was occurring can be gauged from changes in the share of nurses employed in the public sector. The public sector share of nurses in Zimbabwe fell significantly from 58 percent in 1996 to 45 percent in 1999 (Figure 5.6). The number of nurses registered nationally also provides corroborating evidence. The number rose marginally from 15,096 in 1995 to 15,476 in 1999 (an increase of 2.5 percent), while the number of nurses employed in public health institutions declined from 8,635 in 1995 to 7,007 in 1999 (a reduction of 19 percent).

The departure of nursing professionals for the private sector and through emigration led to serious staff shortages in public sector health institutions and an increase in the number of vacant posts. Harare Central Hospital, for instance, employed 676 nurses in 1998 and 594 in 2000 (Table 5.4). The dramatic increase in the number of vacant

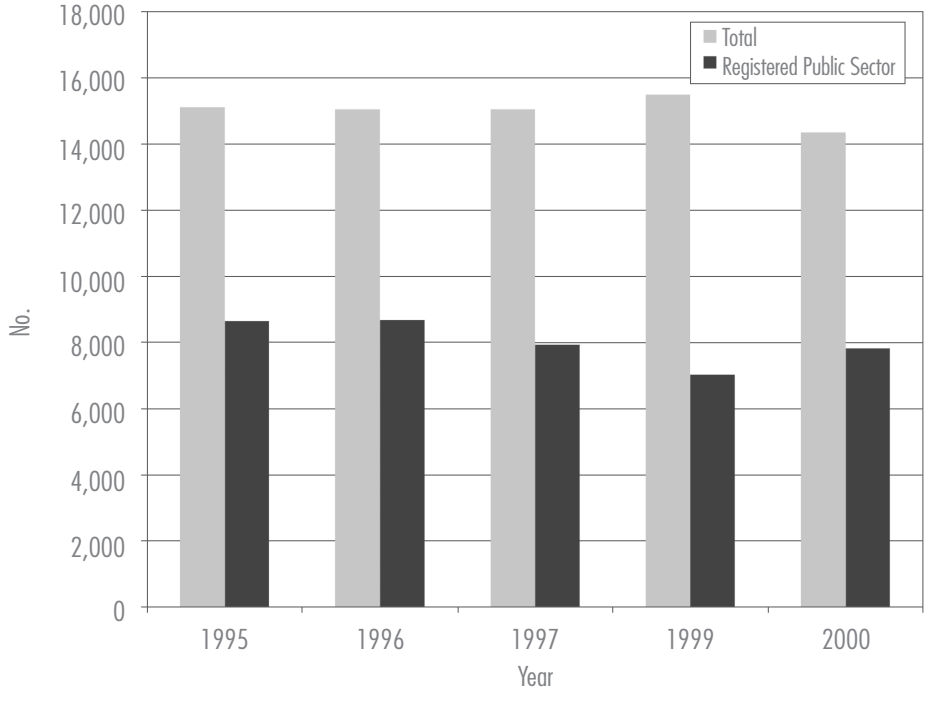


Figure 5.6: Public versus Private Sector Share of Nurses

posts in 2000 was partially due to an increase in the number of established posts from 794 to 934. Gweru Provincial Hospital as well as Kadoma District Hospital, on the other hand, experienced marginal growth in the number of nurses employed during the period studied. Both also recorded an increase in the number of vacant posts owing to the allocation of additional established posts.

Two main factors explain the large number of vacant posts in large urban areas compared to smaller centres. First, nurses in large centres (like Harare) were lured to join the private sector, which offered better returns. Private practices are more prevalent in these urban areas. Second, increased flows of information and easy access to communication networks in urban areas exposed the nurses to job opportunities in developed countries, both regionally and overseas.

The survey of in-country nursing professionals revealed enormous dissatisfaction with working conditions. As many as 67 percent of public sector nurses were considering a move to the private sector. The most common reasons given were better remuneration

Table 5.4: Nurse Staffing Patterns at Selected Public Health Institutions

| | | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|---|---|
| Harare Central Hospital | Established Posts | - | - | - | 794 | 794 | 934 |
| | Number at Post | - | - | - | 676 | 606 | 594 |
| | Vacant Posts | - | - | - | 118 | 188 | 340 |
| Gweru Provincial Hospital | Established Posts | 236 | 242 | 242 | 242 | 242 | 242 |
| | Number at Post | 231 | 230 | 237 | 238 | 232 | 235 |
| | Vacant Posts | 5 | 12 | 5 | 4 | 10 | 7 |
| Kadoma District Hospital | Established Posts | - | 108 | 112 | 116 | 119 | 119 |
| | Number at Post | - | 105 | 90 | 105 | 113 | 112 |
| | Vacant Posts | - | 3 | 22 | 11 | 6 | 7 |
| Epworth Poly Clinic | Established Posts | - | - | - | 7 | 7 | 7 |
| | Number at Post | - | - | - | 5 | 5 | 4 |
| | Vacant Posts | - | - | - | 2 | 2 | 3 |
| Mutare Provincial Hospital | Established Posts | 195 | 195 | 195 | 195 | 195 | 202 |
| | Number at Post | 188 | 190 | 195 | 191 | 185 | 190 |
| | Vacant Posts | 7 | 5 | 0 | 4 | 10 | 12 |
| Kariba District Hospital | Established Posts | 34 | 34 | 34 | 34 | 34 | 34 |
| | Number at Post | 24 | 24 | 24 | 24 | 24 | 24 |
| | Vacant Posts | 10 | 10 | 10 | 10 | 10 | 10 |
| Nyanga District Hospital | Established Posts | - | - | - | - | - | 58 |
| | Number at Post | - | - | - | - | - | 54 |
| | Vacant Posts | - | - | - | - | - | 4 |
| Waverly Clinic | Established Posts | 5 | 5 | 6 | 6 | 6 | 6 |
| | Number at Post | 2 | 2 | 2 | 3 | 2 | 2 |
| | Vacant Posts | 3 | 3 | 4 | 3 | 4 | 4 |
| Rimuka Maternity Clinic | Established Posts | 15 | 15 | 15 | 15 | 20 | 20 |
| | Number at Post | 4 | 4 | 10 | 10 | 11 | 11 |
| | Vacant Posts | 11 | 11 | 5 | 5 | 9 | 9 |
| Nyameni Clinic | Established Posts | 16 | 16 | 16 | 16 | 16 | 16 |
| | Number at Post | 11 | 11 | 13 | 13 | 13 | 13 |
| | Vacant Posts | 5 | 5 | 3 | 3 | 3 | 3 |

and working conditions. Even those who had chosen to remain in the public sector said that they were often involved in "moonlighting" in private health institutions.

As many as 71 percent of the nurses were considering leaving the country. Their most likely destination (MLD) was the UK (30 percent) (Table 5.5). However, a quarter of the respondents (24 percent) preferred destinations within Africa (mostly South Africa followed by Botswana). Other fairly popular destinations cited by the respondents included Australia (6 percent), the USA (3 percent), New Zealand (3 percent) and Canada (3 percent). Even though intentions do not automatically translate into actions, the extent of dissatisfaction in the public health sector was clearly massive.

Table 5.5: Most Likely Destinations of Zimbabwean Migrants

| Most Likely Destination | % |
|---|---|
| United Kingdom | 30 |
| Another Country in Africa | 24 |
| Australia | 6 |
| United States of America | 3 |
| New Zealand | 3 |
| Canada | 3 |
| Other | 2 |
| Not Thinking of Moving | 29 |

N = 157

The study sought to establish the reasons why nurses wanted to migrate. It hypothesized that declining economic conditions would be the primary cause of emigration in the late 1990s and early 2000s. Political factors also gained greater prominence, as the country's major political parties fought fierce battles, first in the 2000 parliamentary elections, and then in the 2002 presidential elections. The campaigns were associated with widespread violence, which was more severe in rural areas. This saw many professionals fleeing for their own safety as well as for that of their children. The working conditions of health professionals are critical to their migration decisions. A study in 1999 revealed that health professionals in Zimbabwe were extremely disgruntled with their working conditions. Professional factors also influenced the decision to emigrate.

Table 5.6: Reasons for Intention to Move

| Reason | % |
|---|---|
| Economic | 55.6 |
| To save money quickly to buy a car, pay off a home loan, or for a similar reason | 56.7 |
| Because of a general decline in the economic situation in this country | 56.1 |
| Because I will receive better remuneration in another country | 54.1 |
| Political | 31.2 |
| Because I see no future in this country | 47.8 |
| Because there is a general sense of despondency in this country | 24.2 |
| Professional | 29.3 |
| Because of a lack of resources and facilities within the health care system of this country | 47.8 |
| Because there is a general decline in the health care services of this country | 43.3 |
| Because the workload in the health services of this country is too heavy | 42.7 |
| To gain experience abroad | 31.8 |
| Because of insufficient opportunities for promotion and self-improvement | 29.9 |
| Because of the poor management of the health services in this country | 29.9 |
| Because I need to upgrade my professional qualifications due to the unsatisfactory quality of education and training in this country | 21.0 |
| Because I cannot find a suitable job in this country | 11.5 |
| Because an unacceptable work tempo is expected of me in this country | 9.6 |
| Because I was recruited to work in the country I intend to move to | 8.3 |
| Social | 24.8 |
| To find better living conditions | 47.8 |
| Because the value systems in this country have declined to such an extent that I can no longer see my way clear to remain here | 34.4 |
| To ensure a safer environment for my children | 25.5 |
| Because of the high levels of violence and crime in this country | 21.7 |
| To join family/friends abroad | 16.6 |
| To travel and see the world | 15.3 |
| Because of family related matters | 9.6 |

N = 157

Note: More than one answer permitted

The survey showed that economic factors dominated the desire to migrate. They included the wish to save money quickly for use in Zimbabwe (mentioned by 57 percent), the general economic decline (56 percent) and the desire for better remuneration (54 percent). The growth of a parallel market for foreign currency exchange on the domestic market made it even more attractive for nursing professionals to move to countries in the developed world to accumulate savings. Professional factors influencing emigration included the lack of resources and facilities within the healthcare system of the country (48 percent), heavy workloads (43 percent) and insufficient opportunities for promotion and self-improvement (30 percent). Major social factors included the desire to find better living conditions (48 percent), the desire to ensure a safer environment for their children (26 percent) and the high levels of crime and violence in the country (22 percent).

Most nurses in Zimbabwe are officially supposed to be on duty for between 31 and 40 hours a week (i.e. about 8 hours a day). However, due to staffing problems, some end up working up to 4 extra hours a day. In the study, some were on duty for more than 50 hours weekly, 10 hours more than the stipulated national average. This is because the shortage of nurses in the country's public health institutions has increased the workload of those who choose to remain. As many as 78 percent of the nurses expressed dissatisfaction over the number of patients they attend to per day, which they regard as extremely high. They blamed emigration for the increase. The migration of nurses is thus both a cause of ongoing migration (by increasing the workloads of remaining health professionals) and an effect (due to the reduction of available health professionals).

The shortage of foreign currency in Zimbabwe has also affected service delivery in most health institutions, which rely on drugs and equipment that are mostly imported from other countries. Nearly 80 percent of the nurses indicated that they lack basic equipment, such as needles and thermometers, at their health institutions. The absence of such basic equipment makes it difficult for nurses to conduct their duties efficiently and negatively affects morale.

Zimbabwe is one of several Sub-Saharan African countries badly affected by the HIV/AIDS pandemic, with an estimated 25–30 percent of the sexually active population infected with the virus.[20] The impact of HIV/AIDS on health system workers was not specifically identified as a reason for migration.[21] However, the Joint Learning Initiative identified three potential impacts of HIV/AIDS on the health workforce.[22] First, the health

sector is losing workers due to the HIV/AIDS pandemic. Nurses are dying and are not being replaced. Second, health workers are faced with extra workloads, as HIV/AIDS patients comprise a majority of their patients. Third, fear of exposure to the disease is itself a source of attrition, especially where precautionary measures are not strictly followed.

The interviews with individual nurses revealed that a sizeable number of health institutions were not taking measures to protect them from the virus. Only 60 percent of the nurses indicated that their health institutions were taking adequate precautions against HIV infection. The absence of such measures creates an unsafe environment for professionals. Not surprisingly, 64 percent said that they were constantly worried that they would become infected through an injury at work. Health workers, particularly nurses and midwives, reported a shortage of gloves which increases their risk of contracting the virus, especially when conducting deliveries. Some nurses suggested that a risk allowance be introduced. The disease has also increased the workload of health professionals, with 66 percent indicating that they find caring for HIV/AIDS patients stressful. In sum, the epidemic is clearly having a major impact on the levels of work stress and perceptions of personal risk. To that extent, it may also be a factor prompting people to move to the private sector or out of the country.

In Zimbabwe, nurses run most health centres situated in the disadvantaged rural areas. As noted, nurses working in rural areas have, over the years, taken on expanded roles as pharmacists, doctors, physiotherapists and so forth.[23] This has negatively impacted on the workload of nurses, particularly those stationed in outlying regions. According to MoHCW estimates, the national nurse/patient ratio in 2000 was one nurse to 700 patients.[24] This study established that only the provincial health institutions had nurse to patient ratios lower than the national average (Table 5.7). For instance, the nurse/patient ratio was 1:177 for Gweru Provincial Hospital and 1:522 for Mutare Provincial Hospital. This compares to a nurse/patient ratio of 1:1,484 at Kadoma District Hospital and 1:3,023 at Nyanga District Hospital. The situation was even worse for nurses at the health centres (where doctor visits are rare). For instance, the nurse to patient ratio at Waverly Clinic (a health centre in Kadoma) stood at 1:7,500 and at 1:10,500 for Epworth Poly Clinic (a health centre on the outskirts of Harare). Nurses employed at health centres clearly had the heaviest workloads, a situation that improved at the district and provincial health institutions level. The study also established that less qualified staff (namely nurse aides) were carrying out many nursing duties at health centres.

Table 5.7: Patient Attendance at Selected Health Institutions in Zimbabwe, 1995-2000

| | | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|---|---|
| Gweru Provincial Hospital | No. of patients | 143,196 | 126,369 | 39,428 | 40,503 | 40,819 | 41,629 |
| | No. at post | 231 | 230 | 237 | 238 | 232 | 235 |
| | Attendance/ nurse | 620 | 549 | 166 | 170 | 176 | 177 |
| Kadoma District Hospital | No. of patients | 192,707 | 133,509 | 181,185 | 182,755 | 180,087 | 166,255 |
| | No. at post | 112 | 105 | 90 | 105 | 113 | 112 |
| | Attendance/ nurse | 1,721 | 1,272 | 2,013 | 1,741 | 1,594 | 1,484 |
| Epworth Poly Clinic | No. of patients | - | - | - | 22,440 | 38,000 | 42,000 |
| | No. at post | - | - | - | 5 | 5 | 4 |
| | Attendance/ nurse | - | - | - | 4,488 | 7,600 | 10,500 |
| Mutare Provincial Hospital | No. of patients | - | - | - | - | - | 112,562 |
| | No. at post | - | - | - | - | - | 190 |
| | Attendance/ nurse | - | - | - | - | - | 592 |
| Nyanga District Hospital | No. of patients | - | - | - | - | 196,297 | 163,247 |
| | No. at post | - | - | - | - | 54 | 54 |
| | Attendance/ nurse | - | - | - | - | 3635 | 3023 |
| Waverly Clinic | No. of patients | 8,000 | 9,500 | 9,500 | 10,500 | 11,000 | 15,000 |
| | No. at post | 2 | 2 | 2 | 3 | 2 | 2 |
| | Attendance/ nurse | 4,000 | 4,750 | 4,750 | 3,500 | 5,500 | 7,500 |
| Rimuka Maternity Clinic | No. of patients | 22,000 | 22,000 | 21,000 | 20,000 | 20,000 | 20,000 |
| | No. at post | 4 | 4 | 10 | 10 | 11 | 11 |
| | Attendance/ nurse | 5,500 | 5,500 | 2,100 | 2,000 | 1,818 | 1,818 |
| Nyameni Clinic | No. of patients | - | 20,821 | 24,009 | 20,608 | 17,915 | 19,243 |
| | No. at post | - | 11 | 13 | 13 | 13 | 13 |
| | Attendance/ nurse | - | 1,893 | 1,847 | 1,585 | 1,378 | 1,480 |

Poor job satisfaction and low morale are endemic among health professionals in Southern Africa.[25] The study showed that nurse professionals in public employment were augmenting their salaries by legal and illegal means. This included moonlighting in private health facilities and attending to non-medical businesses. The public sector is thus largely left with individuals who are poorly motivated to perform their work. However, some remained in the public sector where job security, career advancement, and opportunities for further training were greater.[26]

The migration of skilled health professionals from the country also adversely affected the quality of care in health institutions.[27] This can generally be attributed to low morale resulting from excessive workloads and the stress of dealing with so many dying patients. The shortage of nurses has led to reduced consultation times and diagnosis and prescription of treatment are hurried. Furthermore, more than half (55 percent) of the nurses interviewed reported that they were sometimes forced to perform duties which should ideally be offered by another specialised member of the health team. This practice has had two main consequences: first, it increased the workload of nurse professionals and second, the lives of patients were endangered as general nurses ended up performing more specialised duties beyond their training or expertise.

Rural areas are particularly disadvantaged. They often do not have basic infrastructure such as all-weather roads, electricity and clean water supplies. In addition, rural health centres often lack basic drugs and equipment and are understaffed. This translates into heavy workloads for the few nurses posted in such areas. Because of such factors, the rural to urban movement of health professionals within the public sector became common and the staffing situation in rural health institutions continued to worsen. Some nurses in rural areas moved directly to private health institutions in urban areas, a move that entailed changing both geographical location and employer.

## CONCLUSION

Most of the country's public health institutions had become grossly understaffed by 2003 and the skeletal staff that remained was reeling under heavy workloads. Both urban and rural health institutions were affected by emigration, but the rural areas were hardest hit and served by un- or under-qualified health staff. The situation was better in urban areas, which had alternative sources of medical healthcare in the form of private health

institutions. Besides offering better services to patients, albeit at a higher fee, the private health sector provided an escape route for disgruntled public health sector nurse professionals. But the private sector is inaccessible to the bulk of the population and also acts as a jumping-off point for migration abroad.

At the global level, piecemeal attempts have been made to reduce the migration of health professionals from developing to developed countries.[28] Protocols such as the Commonwealth Code of Practice for the International Recruitment of Health Workers and its companion document cannot yield meaningful results as long as they are voluntary and non-binding. What are needed are policies that reduce the systematic recruitment of nurses by developed countries from poor countries. Of course, such policy instruments need to be sensitive to the needs of nurse professionals, for example, that advanced training can only be met by migration. The challenge then is to create a workable policy that responds to the needs of the nurses, whilst at the same time discouraging developed nations from benefitting unfairly from human resources that they did not invest financial resources in training.

The high rate of nurse emigration from Zimbabwe from the late 1990s led the government to adopt several measures to try to contain the problem. First, it introduced bonding of newly qualified nurse professionals. All nurses who started their training in 1997 and thereafter were bonded by the government for 3 years. However, after the bonding period, the nurses were free to make their own decisions about where they wanted to work. The nurses dutifully served the period of bonding and then migrated to other countries. Thus, bonding only acted as a delaying mechanism to migration and did not address its root causes. Second, fellowship and scholarship programmes, as well as advanced training programmes, were introduced to enhance the capacity of the health professionals in the provision of their services. They were also meant to reduce the migration of nurses who left to further their studies. Third, salary reviews were introduced to cushion health professionals from the effects of inflation and the high cost of living. However, with hyperinflation, the salary reviews constantly lagged behind, negatively affecting the livelihoods of health professionals. Lastly, performance management was introduced in the health sector. While performance management led to greater professional acknowledgement, the results were not generally implemented because of stiff resistance to the policy within the system.

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