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VOTING WITH THEIR FEET

Migrant Zimbabwean Nurses and Doctors
in the Era of Structural Adjustment

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Introduction

This study was written up in 1997/98 in the context of yet another episode of industrial action by medical workers, both professional and non-professional, employed in the Zimbabwean public health sector. The dissatisfaction of government-employed professional medical workers has been common knowledge for some time and is well-documented by researchers such as Mutizwa-Mangiza (1996). That it has not been satisfactorily resolved for both the workers and the government of Zimbabwe is an issue which this research report will, partly, attempt to deal with. The report delves into the problems afflicting the health sector from the points of view of the medical professionals who have chosen to migrate from Zimbabwe in response to the deteriorating workplace situation that they faced in the 1990s. This situation has, in part at least, been a product of the implementation of market-based orthodox economic reforms by the government. Indeed, many of the recent changes and structural transformations that have taken place in the Zimbabwean economy are the result of the implementation of a World Bank/International Monetary Fund (IMF) structural adjustment programme which was officially adopted by the government in 1990. This report attempts to document the views of the migrant health professionals who left the country in response to adjustment-induced deteriorations in their working and living conditions. It also presents the official views of the Ministry of Health on developments in the sector. An analysis of these points of view is undertaken in the light of the data that have been collected in the course of this study; the viewpoints will also be discussed with the aim of complementing other studies on the impact of adjustment on the health sector Zimbabwe.

Zimbabwe is a relative latecomer to adjustment when compared to other African countries such as Ghana, Uganda, Zambia and Tanzania which have had to accommodate IMF/World Bank pressures to implement market reform programmes since the late 1970s and early 1980s. Zimbabwe's first close brush with the possibility of having to adjust according to IMF/World bank prescriptions came in 1984 as part of the attempt to deal with the poor growth in the economy in the wake of the drought of 1982. However, the terms of the proposed adjustment included cutbacks in spending on health and education. The proposals were rejected on social and political grounds by the government since their adoption would have eroded the basis of its support amongst poorer Zimbabweans. Thus, Zimbabwe's health expenditure re-

mained consistently high between 1986 and 1990, with an average of 8% of the national budget spent on the health sector.

However, in 1989, the government suffered a budget deficit of U.S.\$120 million. The country was plunged into debt as the government resorted to borrowing to cover its deficits; by 1992, Zimbabwe's debt service ratio stood at 25.8%. The economic problems associated with the fiscal deficit served, therefore, as the immediate context for the introduction of the economic structural adjustment programme (ESAP) in 1990. The programme was supposed to restore the economy to the high growth levels that were experienced in the 1980s; these averaged about 4% per annum between 1980 and 1989. Until 1989, Zimbabwe had been classified as a lower middle income developing country. After 1989, it descended into the group of low income developing countries. The major components of the adjustment programme included the stabilization of the economy through the adoption of restrictive fiscal and monetary policies; trade liberalization; the privatization of parastatal bodies; a generalized domestic economic deregulation, including the decontrol of prices; and, as an afterthought, a poverty alleviation component intended to cushion "vulnerable" groups such as those who had been retrenched, poor families and children, against the adverse effects of the reform measures.

The incessant strikes that have been witnessed in the health sector throughout the 1990s are just an illustration of some of the major issues and research problems that this report deals with. The report focuses, in very broad terms, on the issues of social provisioning and the networks that people mobilize under conditions of economic stricture. While it is common for researchers to focus on social provisioning and coping mechanisms among the poor under conditions of structural adjustment, it is also important to study other groups who may not be among the poorest in society and who exercise a critical function in the social and economic structures of the adjusting countries of Africa. An insight into the livelihood strategies of such groups could serve the useful purpose of enabling us to understand the nature and direction of changes in the sectors in which they operate. Thus, for example, although Gibbon (1995), Jirira (1994) and Bijlmakers *et al* (1998) have written about socio-economic stress amongst poor households in Zimbabwe and the health implications of such stress, their studies tend to deal with the health sector in terms of its relationship to poor recipients of health services and how their access to such services can be improved. On the other hand, an important component of the health sector is the front line staff such as nurses and junior doctors who have to deal with the poorest sections of the health service-consuming public but whose working conditions, jobs, lifestyles and expectations may also be affected by health budget cuts in ways that have a direct impact on the quality of the health services they deliver. It is, therefore, important to note that the adjustment programmes cannot be understood

solely in terms of their most obvious and immediate impact on the poorest people but also from the vantage point of their effects on the processes of production, retention and remuneration of different categories of actors in African economies and societies.

In addition to the useful insights that could flow from a study of the livelihood strategies of groups such as nurses and doctors, the issue of the retention of professionals and the sustainability of skills production in previously colonised countries needs to be better understood. This understanding, for it to be useful, will have to go beyond generalized statements and aggregations of statistics on the brain drain from Africa to include an analysis of the logic which informs the decisions of skilled people on the continent. The factors that underpin these decisions have not been well researched and understood, with the consequence that attempts by many governments to deal with poor staff morale, poor performance, wastage, shortages and strikes amongst skilled workers are often not based on empirical information and a reasoned understanding of personal and group decision-making processes amongst these workers, some of whom are professionals. This study will attempt to fill that gap and generate information that can be used in policy making on professional staff in the health sector, especially in the context of Zimbabwe.

The study delves into the self-provisioning choices that front line health professionals make in order to defend their present incomes or maximise their future social statuses and incomes under conditions of structural adjustment. The study focuses in particular on junior doctors and nurses from Zimbabwe, although passing reference is also made to the experiences of some senior and middle-level doctors currently in practise in Zimbabwe. Doctors and nurses have dealt with the economic and occupationally-related problems that they face in the 1990s in different ways. Some have left their professions altogether, others have stayed in their professions but split their efforts between the health profession and other professions while others have opted to stay in their professions and improve their positions from within. Given these varieties of responses, the study will focus on the health professionals who have migrated from Zimbabwe but it will also point to other alternatives that have been adopted by similarly placed colleagues.

There is a gender dimension in this study and it derives from the fact that in Zimbabwe, nursing is predominantly a female profession while doctors are predominantly male. Thus, the health sector is segmented by gender and status, with women occupying the lower rungs of the profession where pay is relatively low and conditions of service are poor while men are concentrated in the relatively better paid niches of the health sector where their options are wider, their skills scarcer, and their relative remuneration much better than that of nurses. The nurses studied for this report have mainly migrated to

Botswana while the doctors have mostly migrated to South Africa. This pattern of migration is not unconnected to the segmentation of the health labour market along gender lines. Also, in South Africa, there is a shortage of doctors and the relative ease of entry which the historical-colonial ties between South Africa and Zimbabwe permits, has encouraged Zimbabwean doctors to go there while in Botswana, there is a shortage of experienced and specialized nurses.

Aims and Objectives

The study's major objectives are to:

- i) explore the career experiences of junior doctors and nurses and to understand their livelihood and career choices and strategies within their professions;
- ii) relate these choices and strategies to the economic conditions created by the structural adjustment programme;
- iii) provide empirical data on the professionals in the health sector so that the brain drain can be better understood from their point of view. This will go some way towards enriching the data available on the choices made by skilled professionals under conditions of economic stress;
- iv) enrich the existing understanding of the exodus of skills from the developing countries by emphasizing the personal and national dimensions of the migratory process;
- v) provide Zimbabwean policy makers, and Southern African officials more generally, with some data that can help to refine their understanding of the larger phenomenon of skills exodus from Africa while recognising the peculiarities of specific professional categories in this migration. Structural adjustment in Zimbabwe provides the background against which these phenomena will be examined;
- vi) add to the meagre literature on the professions in Africa as well as on skilled female migration, a woefully neglected area of study in the social sciences; and
- vii) examine and evaluate the official orthodoxies about the causes of and solutions to skilled migration in the health sector.

This study will, therefore, give prominence and voice to the skilled professionals while using the adjustment programme as a focal point around which developments in the health sector as they affect the professions and professionals can be understood.

Literature Review

There is a paucity of data on the professions in Africa. As Mutizwa-Mangiza (1996) has observed, there are still no comprehensive studies analysing the nature of the professions in post-colonial Africa. Most of the literature that is available on specific categories of migrants focuses on low income workers, unskilled migrants and non-professional workers. Grillo (1973) on railwaymen in East Africa, Van Onselen (1976) on miners in Southern Africa, Bromley and Gerry (1979) on casual workers, Hussein (1975) on dockworkers in Port Sudan, Iliffe (1970) on dockworkers in Dar es Salaam, Peil (1972) on Ghanaian factory workers, Crisp (1984) on Ghanaian miners, Sandbrook (1977) on African urban workers, and Waterman (1983) on Nigerian dockworkers have all focused on the experiences of these categories of employees. The limited literature available on the migration of skilled workers is heavily biased towards the migratory patterns from Eastern Europe and Asia. The literature on African migration mainly focuses on the flows of refugees across countries; there is only a very small body of literature looking at the migration of skilled people on the continent. In this category, Rule (1994), for example, looks at recent waves of skilled personnel, made up mostly of white South Africans, migrating to Australia, Canada and the United States of America while Danso (1995) examines the African brain drain from a policy perspective. Carey (1993) argues for the continued relevance of dependency theory in explaining the migration of highly skilled human capital from developing countries in general.

Thus, most of the works that are available on migration deal primarily with the flow of unskilled labour while those works that do deal with skilled labour migration tend to aggregate the data, discussing numbers in general terms and taking a macro perspective of the issue. Another neglected area which this report touches on in passing is the issue of South-South skilled migration. This type of migration had been going on prior to colonisation in Africa and has taken on new dimensions as workers search out the most favourable labour markets and environments in which to organise their livelihood. South-South skilled migration has not been paid much attention given that the concerns of the North have tended to overshadow the relationships between countries of the South in the area of organised and unorganised skills exchanges. This study indicates the factors that attract skilled labour from Zimbabwe to Botswana and South Africa.

Similarly, United Nations agencies such as the International Labour Organisation and the United Nations Development Programme and the European Community-funded International Organisation of Migration have developed programmes meant to facilitate the return of skilled Africans to their countries or regions of origin so that they can use their skills where they are most needed. In Uganda for example, the UNDP's programme to transfer skills through expatriate nationals has received mixed reviews because it is perceived to be rewarding those who allegedly left the country in the lurch and pursued lucrative careers elsewhere during the Amin and Obote years while punishing the committed professionals who stood by their country through thick and thin. This programme is viewed as divisive and likely to sow the seeds of discord in the different areas in which the expatriate nationals work.

The IOM runs a European Union-funded Reintegration of Qualified Nationals' Programme which focuses on repatriating African people with skills that are in short supply to the countries in need. During the period 1995-1996, the IOM repatriated nine doctors, one of them a Zairean and all of them male, and one female nurse trained in occupational therapy. However, it is doubtful that these doctors, all but one of them specialists, would have had problems returning to Zimbabwe without the assistance of the IOM. Anecdotal evidence based on conversations with Zimbabweans abroad indicates that the return of talent programme tends to be viewed by nationals returning to their countries or those wishing to study abroad for a short while, as a convenient way of saving on airfares, shipping and related costs, to their homes or places of study.

The IOM does not in any way guarantee that the conditions of service, salaries and related benefits which the professionals were used to whilst abroad will be maintained or that the local situation will improve. Thus, it might be that the very same specialized people who are brought back are the ones most likely to leave precisely because of their marketability abroad. This was the case in the Zimbabwe of the 1980s when qualified citizens left to join European, American and international organisations as a reaction to the state's over-regulation of the entire society. In many sectors, it is now the most entrepreneurial and the most skilled who are returning to set up practices and businesses under the new conditions of deregulation. Most of these people are not sponsored by any organisation and, in fact, the largest numbers of migrants within Southern Africa are the unemployed and unskilled men.

The IOM holds that 50-60,000 middle and high level managers emigrated from Africa during the period 1986 to 1990 while 100,000 experts from developed countries are currently employed in Africa. Thus, unless the returned Africans are employed on the same terms as the Western expatriates, it is highly unlikely that the on-going exodus of skilled professionals from Africa will be altered. The literature on the brain drain might, following the IOM

(1995), cite "...wars, poverty, unemployment and environmental degradation...", to explain the outflow of skilled personnel from Africa, but unless it deals with the internal, national and personal issues that generate out-migration, the solutions that are proposed will continue to reproduce a balance sheet that reflects an increased out-migration of African professionals and increased immigration of western expatriates. For, while African governments may accept funding to return qualified people to Africa, the very structures and processes that facilitate their out-migration remain in place and, in the case of Zimbabwe, accelerate the process of out-migration of professionally qualified people. Needless to say, the IOM does not problematise the conditions it is returning the professionals and skilled people to in the long term since it cannot pay their salaries, protect their earnings from adjustment-induced inflationary pressures, stabilise most of the African polities, provide decent health, education and other services on a sustained basis, help them to access the technologies necessary for their professions, and provide stable markets for their services and products. This study will, hopefully, help to pinpoint the personal and wider national issues that underpin the flow of skilled health professionals from Zimbabwe.

In Southern Africa, discussions on the migration of labour tend to dwell on unskilled male labour migrancy. Migrant skilled workers are often lumped with expatriates and are treated as people who create skilled labour shortages in their countries of origin or take away jobs meant for local people. This currently tends to be the discourse in South Africa. However, there is still very little data on the migration experience from the point of view of the migrants themselves. There has been an assumption that skilled migrant workers are a privileged crust. This is a perception that has been strengthened by earlier writings, like those of Saul, Waterman and others, on labour aristocracies in Africa. Casual observers have often been quick to categorise skilled workers and professionals as labour aristocrats. As a result, there has been relatively little interest in studying them and their patterns of movement around the world. Attention has, instead, mostly focused on the poor, especially the peasantry and unskilled factory labourers, who were seen as the true makers of history.

Given the dominance of this perspective, it is also not surprising that the mobility of women professionals across national boundaries has not received much attention. It is assumed that African women migrate mainly through marriage and that their mobility is confined to their national boundaries. There is some literature on female migration in Africa but this literature mostly focuses on the struggles, triumphs and tribulations of poor and unskilled women, predominantly in the towns. Barnes and Win (1992) on poor women in Harare, Sudarkasa (1973) on Yoruba women in Nigeria, Schuster on working class women in Lusaka (1979), Little (1973) on women in different

parts of Africa, and Pellow (1977) on women in Accra have produced part of this body of literature on African women. Also, Gaidzanwa and Cheater (1996) have suggested that in Southern Africa, the experience has been that males migrate for labour, education, war and other purposes while women either tend the hearths and wait for their men to return or follow men into the towns through marriage. Yet, anecdotal evidence suggests that there has been female mobility across national boundaries although this migration has not been explored or theorised sufficiently. It is a gap which this study will attempt to fill by focusing on the migratory movements of female Zimbabwean nurses.

The literature on the medical profession in Zimbabwe is also quite scanty. Gelfand (1988), for example, has documented developments in the profession during the colonial era. More recently, Mutizwa-Mangiza (1996) has explored the nature and extent of medical practitioners' autonomy and the dominance of government-employed doctors in Zimbabwe. Her study focused on the degree of control which medical professionals exercise over the technical aspects of their work, the determination of the terms and conditions of medical work, the regulation of medical education, and licensing and discipline within the profession. Although Mutizwa-Mangiza (1996) concluded that all grades of doctors in government employment exercised considerable clinical autonomy, she also noted that their clinical autonomy was constrained by severe breakdowns of essential equipment and shortages of all types of resources ranging from human and financial to professional and material resources. Mutizwa-Mangiza concludes that the doctors enjoyed economic autonomy "largely by default". In the face of these findings, this study attempts to explain the migration of junior doctors and nurses from Zimbabwe by assessing their workplace experiences. The study is based on interviews and responses to questionnaires administered to doctors and nurses who have migrated. The information obtained through the questionnaires was supplemented with interview data from doctors and nurses who are still in the public and private sectors in Zimbabwe. The findings are analysed in the light of developments in the health sector since independence in 1980.

As has been indicated in the introductory section to this study, the SAP-related literature on the health sector and the medical profession in Zimbabwe has tended to focus on the erosion of access to health care, the declining quality of health services, and the consequences of these SAP-related outcomes on the livelihood of the working poor. Various useful policy recommendations have also emanated from the studies on how access to affordable health care by the poor can be maintained (Gibbon, 1995; Bijlmakers *et al* 1998). However, this literature places emphasis on the state as the major player in health delivery and the populace as consumers of health services while ignoring the health professional as a major actor in the health sector. As a result, most of

this literature focuses on the health professional in terms of their absence or presence and with regard to the ratios of medical professionals to patients. This is an approach which is both partial and unsatisfactory and which this study attempts to redress.

The History of the Modern Medical Profession in Zimbabwe

For this study to be useful, it will be necessary to outline the history of modern medicine and the medical profession in Zimbabwe. For this purpose, perhaps the most important thing to note from the outset is that the development of the medical profession was mainly shaped by the colonial history of Zimbabwe. When the British South Africa Company set up settlements in Zimbabwe, it immediately confronted a need to provide the settlers with health services that were relatively comparable to the standards that they previously enjoyed in Britain. In fact, some of the leading lights of settler society, such as Sir Godfrey Huggins and Starr Jameson, were themselves medical men. Cecil John Rhodes is supposed to have procured a doctor to cure King Lobengula of the Ndebele of gout, thus earning the King's gratitude. David Livingstone, a missionary who was one of the first white people to visit Zimbabwe, was also a doctor. Central to the medical challenge which the early white visitors and settlers defined for themselves was the need to devise remedies for coping with the health demands of the "unusual" climate of the tropics. It is perhaps for this reason that medical practitioners were included among the first settlers in Zimbabwe in the early twentieth century. The health system of the colonial era was, therefore, geared primarily towards meeting the needs of the settlers in colonial Zimbabwe and the system granted considerable autonomy to the medical profession, an autonomy that was widely respected by the colonial authorities.

Discoveries in the field of tropical medicine were very important for the colonial project because public health services both for the settlers and the colonized were crucial for the prevention and treatment of infectious diseases associated with urbanization and industrial employment as well as rural and urban poverty amongst the colonized. In colonial Zimbabwe, medicine was organised along racial and class lines with medical clinics for whites, blacks, Coloureds and Asians organised parallel to each other. There was also a private medical sector for those who were able to afford private care and treatment. In rural Zimbabwe, where there were few medical facilities, missionaries stepped in and set up clinics and hospitals primarily for the colonised black population. Access to the medical profession was regulated by the Health Professions Body that was dominated by state-employed and private white practitioners. The white elite in medicine was, thus, able to set the

tariffs and enforce its preferred ways of regulating the profession through the law and through practise.

Most of the first generation of nurses and doctors in colonial Zimbabwe were trained in Britain and the other British colonies. This is because the medical school in Zimbabwe was only set up in the 1960s within the University College of Rhodesia and Nyasaland during the days of the Federation. Given that most of the black population were unable to access post-secondary education in Zimbabwe during the colonial era, the only alternatives for the training of nurses, doctors and other professionals lay outside Zimbabwe, usually in South Africa or the United Kingdom. By default, prior to the 1960s, most doctors and nurses were whites who trained outside Zimbabwe. Thus, the medical profession benefited from the racial privileges accorded to white people, especially in those professions which many blacks were unable to access. The fact that wages in all occupations were stratified by race placed white medical practitioners at the pinnacle of the profession politically, administratively and economically.

The colonial economy was nominally a free market one but, in reality, it was closely regulated, especially after the Unilateral Declaration of Independence (UDI) in 1965. In this context, doctors were able to treat their private patients in government hospitals. Doctors could also work as consultants for government hospitals so that in general, there was room for some practitioners to make a good living through private practise or through a combination of private and government practise. Eventually, when the government was able to afford to hire all doctors on a full time basis as the pool of doctors and nurses expanded, the white doctors and nurses were paid higher salaries which assured them a decent living in the colony.

The privileged position of the medical profession was further enhanced by the demonisation of traditional medicine and medical practitioners during the colonial era. As Chavunduka (1994) has observed, the medical establishment was able, during the colonial era, to exclude traditional healers and medicine from the domain of accepted medicine. Against the background of the prestige that was accorded to western medicine and practise, entry into the medical profession by both black and white people was seen as the pinnacle of achievement in personal educational and professional development. Thus, amongst black people, males were encouraged to become doctors while females were encouraged to become nurses. These were seen as the best professions, not least because, in the case of nursing, trainees were paid. Black women could become assets to their families as soon as they had acquired the qualifications that gained them entry into nursing schools. This was in contrast to teaching which was, prior to the establishment of a medical school in Zimbabwe, the most prestigious profession for both men and women. However, teacher trainees were not paid during their period of training. Thus,

despite the racial discrimination in pay and conditions of service which disadvantaged blacks in the medical profession, they benefited comparatively since the prestige of the profession in their community also placed them more favourably in the labour market in comparison to other blacks in different professions and occupations.

Table 1 shows the numbers of medical school graduates from the University of Zimbabwe in the colonial era. The school opened in March 1963 as the medical school of the Federation's university and the first group of medical students graduated in 1968. In 1971, the first intake of the University of Rhodesia entered the school. The medical degrees of the Federation's medical school were awarded by the University of Birmingham. The intake of 1975 comprised Birmingham and University of Rhodesia (as the colonial university was called) students in equal numbers. The figure for 1976 includes the last two Birmingham graduates who had to repeat their fifth year in 1975. Students were enrolled in a five year programme of study and their sixth year was an internship year where they were attached to hospitals as house officers.

Table 1: Number of medical school graduates during the colonial era

Final Year Class of	Africans		Europeans		Others		Total
	Male	Female	Male	Female	Male	Female	
1968	1	0	9	4	2	0	16
1969	2	0	13	1	4	1	21
1970	3	1	10	4	6	2	26
1971 (UR)	7	0	18	5	7	0	37
1972	4	0	8	1	4	0	17
1973	5	0	14	3	3	0	25
1974	14	0	18	5	3	3	43
1975 (UR&Bmh)	8	0	21	3	2	0	34
1976	9	2	16	5	4	1	37
1977	5	1	21	5	3	0	35
1978	10	1	15	4	2	1	37
1979	9	0	26	8	0	0	43
Total	77	5	189	48	40	8	367

Source: Secretary to the Medical School, University of Zimbabwe.

This was the situation that existed when independence was attained in 1980. Following independence, one of the first issues that was tackled by the new government was that of racial discrimination in all aspects of life in Zimbabwe. Naturally, the health system was one of the areas that was supposed to be addressed as part of the attempt to bring about change towards a better life for the bulk of the black population that had suffered under colonialism and settler rule. Equity was a burning issue at the time and since the ZANU (PF) government espoused a socialist line, it sought to ensure equal access to health for all the people of Zimbabwe.

Prior to making changes to the social and economic structures that it had inherited, the government of Zimbabwe set up a commission, chaired by Roger Riddell, to inquire into incomes, prices and conditions of service in the country. The Riddell Commission dealt with the issue of skill retention and the narrowing of wage differentials in post-independence Zimbabwe. On the issue of reduction and/or freezing of wage levels for skilled workers and professionals so that the wages of the unskilled could be raised gradually, the commission noted that this might result in the emigration of those people with mobile skills and the subsequent lack of incentive to train for skilled work. The commission recognised South Africa as an important regional market for such skills but also noted that the apartheid system that was still in existence at the time placed a racial boundary around the skill drain so that only white skilled people would be attracted to South Africa. The commission also noted that the costs and uncertainties of moving to other labour markets in Africa and beyond are high.

One of the issues that is pertinent for this study was the commission's observation on skilled people's mobility. The commission made the following submission:

People are not completely mobile. Multiple ties (such as the need to finish the schooling of family members, the desire to be near family and friends, the desire to stay within a more familiar work and living environment and the uncertainties associated with alternative localities), the costs of moving, restrictions imposed on immigrants by other countries, the desire to protect pension and seniority rights and similar factors mean that there will be skill retention even if real or relative wages slip. The unknown factors are how many skilled people will go, how vital their skills are and what rate of skill loss would be associated with each rate of cut of real wages. (Real wage rates need not be cut by actually reducing money rates. Frozen money rates can mean real cuts alongside inflation and tax reform, but the effects and trade-offs are the same in the final analysis.) There are non-wage factors operating in terms of "push" and "pull" effects on the decision of people to stay or leave. These non-wage factors can override wage considerations regardless of what is done to wage rates, and hence it is not realistic to frame a skills acquisition and retention policy on the basis of wage structure alone. In other words, the "skills problem" would remain regardless of what is done in terms of wage rates and hence a wage focus on the problem is misplaced. (paragraphs 620 and 621, Riddell Commission Report)

The observations made by the Riddell Commission regarding wages, skills and emigration from Zimbabwe will be evaluated in the light of the experiences of the junior doctors and nurses who were the focus of this study. However, the policy changes that preceded the migrations need to be understood in as much as they clarify the factors that influenced the decision of particular nurses and doctors either to stay or to leave Zimbabwe after 1988.

At independence, the government set up a National Health Service Programme which was designed to create a comprehensive and integrated health system. The thrust of government policy was growth with equity in order to create a socialist and egalitarian Zimbabwe. Health was conceptualised as a development issue and so, emphasis was placed on the need to plug the gaps and bridge the inequalities between races and classes in the area of health care. The Primary Health Care approach was adopted in order to improve the access of Zimbabweans, particularly in rural areas, to health care. The implication of this policy was that there would be a rapid increase in the number of establishments in the health sector as well as a conceptual shift in the roles and responsibilities of the different personnel responsible for health care delivery. There was also to be provision for district, provincial and central hospitals meaning that all 55 districts in the country would be served by a hospital, with provincial and central hospitals providing specialised back-up on referral from the districts. All these changes had significant financial consequences for the government.

While the government's interventions and budgetary allocations to health after independence appeared to be growing, the value of the Zimbabwe dollar was declining significantly against major currencies so that many of the essential inputs necessary for ensuring a functioning health system were adversely affected. Particularly badly hit were such inputs as drugs, equipment and salaries. This factor significantly contributed to the subsequent migration of medical personnel from Zimbabwe. Table 2 summarises the average exchange rate of the Zimbabwe dollar against the U.S. dollar between 1980 and 1990.

Table 2: The exchange rate of the Zimbabwe to the US dollar between 1980 and 1990

Year	Exchange rate Z\$ per US\$
1980	0.643
1981	0.689
1982	0.757
1983	1.011
1984	1.244
1985	1.612
1986	1.665
1987	1.661
1988	1.802
1989	2.113
1990 (mid-June)	2.470

Source: Economist Intelligence Unit, 1990.

By the end of 1990, there was serious talk about the need for drastic economic restructuring beyond the efforts which had been made in the 1980s to stabilise the economy. The Zimbabwe dollar continued to deteriorate in value against

major currencies. By 1997, the Zimbabwe dollar had suffered a steady decline until it stood at Z\$11 per US\$. This is clearly brought out in Table 3.

Table 3: The decline of the Zimbabwe dollar against the US dollar, 1992–1997

Year	Exchange rate of Z\$ per US\$
1992	5.0
1993	6.0
1994	7.0
1995	8.3
1996	10.2
1997	10.1

Source: Central Statistical Office, *Quarterly Digest of Statistics*, various issues.

It is also important to indicate the relationship between the earnings of high income urban workers and the consumer prices that prevailed at different times so that the factors affecting the wages of doctors and nurses in the pre-adjustment period can be appreciated. Table 4 shows the indices of consumer prices and earnings for high income earners, the group to which nurses and doctors most likely belong in terms of lifestyle and pattern of expenditure.

Table 4 : Consumer prices and earnings for high income Zimbabweans, 1984–1991 (1980=100 : annual averages net of sales tax and excise duty)

Year	Figure	% change	Earnings	% change
1984	172.4	12.7	162.9	10.1
1985	190.9	1.0	184.1	13.0
1986	218.7	14.6	201.6	9.5
1987	244.2	11.7	223.6	10.9
1988	260.4	6.6		
1989	286.1	9.9		
1990		13.6		
1991		12.5		
Average				
June '90/June '91		23.7		

Sources: Central Statistical Office, *Quarterly Digest of Statistics*, Reserve Bank of Zimbabwe, Zimbank.

The ambitious post-independence health and development programme of the Zimbabwe government was curtailed by the following factors: the removal of subsidies on basic consumer commodities such as food in 1982, the wage freeze of 1982, the devaluation of the Zimbabwe dollar between 1982 and 1984, and the restrictions on government spending in 1983 and 1984. All these measures eroded the buying power of the consumers, none more so than the 100% increase in the price of maize meal, 25–30% increases in the bread price, and 25% increase in the price of cooking oil that were registered in 1982–83. The increases in the prices of electricity, transport and fertilisers also had knock-on effects on food and other prices. Given that doctors and nurses are in the socio-economic groupings that prefer to consume imported goods such

as electronic appliances, cars, clothes and other commodities, the devaluation of the Zimbabwe dollar had negative effects on their lifestyles as the prices of such goods on the domestic market increased significantly during this period.

Apart from the developments in the economy, there were attempts to train staff in order to make the post-independence health aspirations of the country a reality in ways that were to the advantage of the poorest people of Zimbabwe. However, when the first National Manpower Survey was conducted and the results published in 1983, it was quite clear that there were problems of absolute numbers as well as those of distribution of skilled health personnel. If the 1983 and 1988 numbers of doctors and State Registered Nurses are compared in terms of their distribution in the different levels of government as well as in the different sectors of the economy, it becomes clear that there has always been a problem of staffing in the public service, especially with regard to medical personnel. These problems were not getting any better by 1988 when the first ever strike by doctors took place in Zimbabwe. Table 5 shows the distribution of doctors and nurses in the governmental and non-governmental sectors in Zimbabwe as of 1988.

Table 5: The distribution of doctors and nurses in Zimbabwe as of 1988

Year	Doctors	Govt.	Mission	Industrial
1983	471	453	1	17
1988	533	n/a ¹	n/a	n/a

Year	Nurses ²	Govt.	Mission	Industrial
1983	2,113	1910	133	70
1988	997	n/a	n/a	n/a

¹ n/a means not available.

²Nurses refers to State Registered Nurses.

Source: Ministry of Health, Harare.

While Table 5 is not complete, especially for 1988, the Ministry of Health reported that in 1989, there were 500 government doctors with 93 of them being specialists and 407 serving as general practitioners. It is, therefore, reasonable to infer that at least 38% of the doctors in Zimbabwe in 1989 were in government employment while the remaining 62% were in the private sector. This inference is based on the available statistic which showed that in 1989, there were 1,290 registered doctors in Zimbabwe. The mission sector started off employing a small number of doctors, the majority of them expatriates but their numbers have increased so that by June 1996, according to the Secretary for Health, 73% of the doctors in the provinces and rural areas were expatriates.

On the numbers of State Registered Nurses in Zimbabwe, it appears that there was a progressive reduction in the numbers of SRNs in government

service given that in 1989, 5,551 SRNs were reportedly practising in Zimbabwe. If we accept the 1988 figures for SRNs in government service, by 1989, there was at least a 10% reduction in the numbers of SRNs in the employment of the government. This fact accords with the sentiments expressed by the Director of Nursing as cited elsewhere in this report.

As can be seen from the figures, in the period up to 1988-89, the government's share of skilled health professionals was not increasing very dramatically despite the fact that the thrust of policy was towards providing health care to all Zimbabweans, especially those earning low incomes. In the case of SRNs, the numbers in government service were actually declining in real terms as the population grew and many nurses left for other sectors of the economy.

While government had targets that it wanted to meet in terms of health provision per unit of population, the supply of health personnel in its service made these plans unworkable. The government used the WHO standard of 1 doctor per 5,000 people as the ideal ratio for which it aimed while that for SRNs was 1 per 1,000 people. By 1988, the ratios were 1 doctor per 57,000 and 1 SRN per 873 people respectively. The situation was worsening in personnel terms with personnel abandoning government service and joining the private sector or migrating. It is this dynamic that the report attempts to deal with in the next section.

Lastly, the numbers of expatriate doctors can also be seen as a proxy for the shortage of staff in the governmental sector. The distribution of expatriate and Zimbabwean doctors employed in provincial and central hospitals is brought out in Table 6.

Table 6: The distribution of Zimbabwean and expatriate doctors by province

Province	No. of Zimbabwean doctors	No. of expat. doctors
Mashonaland East	16	8
Mashonaland West	17	12
Mashonaland Central	14	7
Midlands	15	18
Manicaland	18	7
Matabeleland South	6	12
Matabeleland North	5	7
Masvingo	6	7
Harare	145	15
Parirenyatwa	70	27
Chitungwiza	10	6
Mpilo	80	36
United Bulawayo Hospitals	36	13
Ingutsheni	2	5
Total	430	180

Source: Ministry of Health and Child Welfare.

As is evident from Table 6, the proportion of expatriate doctors in government service had increased to nearly 42% by 1994. In 1983, 1984 and 1985, the percentages of expatriate doctors in government service were 6.6%, 5.5% and 8.3% respectively. By 1996, the role of expatriate doctors had become even more significant as is brought out in Table 7.

Given that expatriate doctors cost additional sums to transport to and from their countries of origin, it is evident that there is a problem in those aspects of the way the health system functions which makes it difficult to employ and retain Zimbabwean doctors in government service.

Expenditure on health also began to falter as the balance of payments problems of the state became more acute in the course of the 1990s. Table 8 shows the government's nominal and real expenditure on health over the period 1988–1993.

Table 7: The distribution of Zimbabwean and expatriate doctors in the health service, 1996

Medical doctors at Mission hospitals	
Approved posts	80
Posts filled	50 (62.5%)
Expatriates	44 (55%)
Government hospitals in the provinces	
Approved establishment	228
Posts filled	175 (59%)
Expatriates	78 (39%)
Medical doctors at both government and mission hospitals	
Approved establishment	308
Posts filled	225 (73%)
Expatriates	122 (54%)

NB: The proportion of expatriates could have been much higher than the 54% average reported in Table 7 but for the fact that in 1995, the government adopted a deployment policy whereby Zimbabwe doctors were required to serve at least one year before going for post-graduate studies.

Source: Secretary of Health, GOZ. 1997.

Table 8: Nominal and real expenditure of the government on health, 1988–1993

Year	Sum in ZS (million)	Budget share	Real expenditure per capita	Real expenditure (%)	
88/89	329.0	6.0%	403.1	12.39	+1.9
89/90	421.4	6.5%	453.0	13.50	+9.0
90/91	566.8	6.8%	513.4	14.78	+9.5
91/92	631.4	5.7%	433.9	12.14	-17.9
92/93	802.5	6.0%	396.3	10.74	-11.5

Sources: Government of Zimbabwe; Chisvo (1993); and Lennox (1994)

The trends in wages at this time was quite alarming with erosions in real wages being felt across the board by all wage and salary earners. Table 9 shows the trends in wages and salaries between 1979 and 1989 in the major sectors of the economy.

Table 9: Trends in wages and salaries in the economy between 1979 and 1989

Sector	Change in nominal wage	Change in real wage
Agriculture	257.3%	31.3%
Domestic service	291.8%	18.7%
Non-agricultural	212.0%	-3.5%

Source: Economist Intelligence Unit, 1990.

As can be seen from Table 9, by the time the first doctors' strike occurred in 1988, there had already been a significant erosion in people's real wages across the board in Zimbabwe. In the post-1988 period, price rises were quite dramatic with two digit inflation being experienced. In 1991, the inflation rate was officially estimated at 24%, although this was clearly an underestimate. By 1992, the real inflation rate was estimated at about 52% judging by the interest rates that were being offered in the financial sector. What is clear is that real wages fell very dramatically, especially amongst civil servants. According to the Economist Intelligence Unit, the greatest declines in living standards occurred among people in the middle to higher income brackets because of the stagnation in real incomes and the adverse impact of steep progressive taxation which placed many graduates in the civil service at the upper levels of the tax ladder. This was the context in which the structural adjustment programme was initiated in 1990.

Clearly, by the time the structural adjustment programme was introduced in 1990, wages had already been eroded in real terms, people's standards of living were declining drastically, and employment was falling in many key sectors as tables 10 and 11 illustrate. The adjustment programme was to feed into and radically exacerbate the situation.

As can be seen from Table 10, real wages declined dramatically in the public sector over the entire independence era and, as Collier (1995) has indicated, inflation has grown faster during the era of liberalisation in Zimbabwe.

Table 11 indicates the erosion of jobs in the public sector at the inception of the adjustment programme after a period of post-independence growth. In the health sector, the stagnation of growth in employment has negative consequences which will be discussed in the section dealing with health pro-

Table 10: Real 1990 and 1993 average annual earnings as a percentage of the 1980 level

Sector	Period	
	1990/1980	1993/1980
Agriculture	130	51.5
Mining	117	81.5
Manufacturing	105	69.2
Electricity and water	95	68.4
Construction	77	44.3
Finance and real estate	95	67.6
Distribution, hotel and restaurants	84	57.7
Transport and communications	91	56.1
Public administration	61.5	34.4
Education	83.2	50.5
Health	91.2	54.2
Private domestic	82	38.4
Other services	80	49.2
Total	103	61.9

Source: *Quarterly Digest of Statistics* and unpublished CSO data as quoted in "Beyond ESAP", Zimbabwe Congress of Trade Unions, Harare, 1996.

Table 11: Percentages of employment growth before and during the adjustment programme

Sector	Period		
	1980-90	1985-90	1991-94
Agriculture	-1.2	1.2	2.8
Mining	-1.2	-0.9	0.2
Manufacturing	2.9	2.9	0.9
Electricity and water	2.6	3.0	-0.7
Construction	6.1	2.9	4.2
Finance	3.5	2.0	6.6
Distribution, hotel and catering	3.6	3.7	2.6
Transport and communication	1.9	1.0	-0.1
Public administration	2.3	0.8	-3.6
Education	11.7	4.4	1.0
Health	5.5	4.9	-0.7
Private domestic	-0.7	0.7	0.0
Other services	5.2	5.0	6.1
Total	1.8	2.4	1.6

Source: *Quarterly Digest of Statistics* and unpublished CSO data as quoted in "Beyond ESAP" Zimbabwe Congress of Trade Unions, Harare, 1996. 1994 data based on first three quarters.

professionals' responses to efforts to reduce the budget deficit through the trimming of the civil service and the erosion of public sector wages. By 1996 when the first phase of the SAP was over, the doctor to patient ration stood at 1:70,000 in the rural areas and that of nurses to patients stood at 1:1,000, a far cry from the WHO ideals that were embraced at independence by the Zimbabwe government.

Methodology

The primary data for this research were mainly gathered through individual interviews, focus group discussions and questionnaires administered to medical professionals in Zimbabwe, Botswana and South Africa. In addition, Ministry of Health officials in Harare and Bulawayo were interviewed about their perceptions of the migration of medical professionals from Zimbabwe. Their views were incorporated into this research in order to allow insights into official perspectives on migration and the brain drain as they affect the health sector.

It was very difficult to obtain hard data on the number of Zimbabwean health professionals working outside the country. The Ministry of Health did not have precise figures because the migrants left under less-than-ideal circumstances, especially after strikes, and, as such, were not willing to announce their destinations. The migrants frequently choose to keep their registration in Zimbabwe active so that it is difficult to tell at any one time, which practitioner is actually on the ground and which one is not. There was a lot of hostility and ill-feeling towards the health professionals in some quarters in the Ministry of Health and this was reciprocated by the migrants who felt used and unappreciated as health practitioners in Zimbabwe. It was not surprising that most of the migrants were not eager to be traced, still less to be questioned and researched by a Zimbabwean about their jobs in Botswana and Zimbabwe. Most of them were afraid that the government of Zimbabwe, through the Ministry of Health, was pursuing them for retribution and that, in any case, they risked having their contracts terminated if they said anything that was remotely uncomplimentary about the Ministry of Health.

The first batch of 50 questionnaires produced for the study went to two research associates based in Botswana and one associate in South Africa. These questionnaires, distributed in February 1996, were supposed to have gone to the doctors and nurses who were known to the three associates enlisted to help with the study. There was a covering letter that accompanied the questionnaires. The letter outlined the study, its purposes and the role of the respondents in the realisation of the objectives. Given the lack of a pre-existing and systematic population of respondents, it was necessary to depend on word of mouth from former classmates and colleagues of the doctors and nurses who had migrated. Needless to say, the responses to the questionnaires were very few; only five doctors, based in South Africa, responded to the questionnaire because they knew the research associate and

her husband as colleagues and the research associate had discussed the study with them in advance. None of the nurses in Botswana except two who were personally known to the researcher bothered to respond.

Given this abysmal response rate which was also exacerbated by budgetary constraints associated with the fact that the potential respondents were spread across Botswana, South Africa and Namibia, it became clear that there was a need to rethink the data gathering method and devise alternative ways of procuring the desired information. The principal researcher established links with a contact in the medical profession in South Africa and sent thirty questionnaires to him for administering. However, he was involved in an accident and the questionnaires that had been sent to him were destroyed. Given that considerable groundwork needed to be done to win the confidence of respondents before questionnaires could be administered to them, it was decided to seek the assistance of a senior nurse who was working as a migrant in Botswana and who was friendly with two doctors and three nurses known to the principal researcher. The senior nurse hosted one of the study's research associates in Botswana while she conducted some interviews and group discussions. Through this method, the research associate was eventually able to conduct a focus group discussion with six nurses. She also interviewed five of the nurses and completed their questionnaires with them. Furthermore, she was able to procure information from the two doctors using the questionnaire prepared by the principal researcher.

In a subsequent visit to Botswana, the principal researcher was able to procure data on five nurses, four through a focus group discussion and the fifth, a male nurse, through a visit to a government hospital in Gaborone. Five questionnaires were filled out by nurses who had been "conscientised" by an associate of the principal researcher who was also a migrant nurse working in Botswana. Subsequently, the research associate in South Africa was able to use the Botswana experience to conduct interviews by first establishing a rapport with the respondents before sending them questionnaires or administering them.

In all, full information was obtained on a total of 20 nurses and 19 doctors. The data collection exercise involved the research associates in three focus group discussions in Botswana and South Africa. The principal researcher too conducted one focus group discussion with four nurses in Botswana. Within Zimbabwe itself, the principal researcher sought the views and perspectives of doctors and nurses who, for whatever reason, remained in the country. A total of 14 doctors and 25 nurses in this category were interviewed formally and informally in Harare and Bulawayo. Government health officials in both cities were also contacted for their perspectives on developments in the health sector. Among the officials spoken to were a urologist, a gynaecologist, a general surgeon, an ophthalmic surgeon, a general medical practitioner, two

nursing tutors, and four senior nurses. Furthermore, an attempt was made to get an insight into the views of health professionals who had left the health sector but not Zimbabwe. In this category, eight nurses who had left the government service and were in the private sector were contacted while one nurse who left the public health sector for private medical practise was interviewed. The information obtained in Zimbabwe from these different categories of people was used to enrich qualitative aspects of the narrative in this report.

Preliminary Observations from the Data Collection Process

From the insight gained during the data gathering process, it was clear that the population of junior doctors and nurses who had migrated out of Zimbabwe did so under a political and social atmosphere which demonised those who left the public service. Since 1988 when the first doctors' strike took place, there has been a lot of ink spilt on the merits of strike action by public servants in Zimbabwe. The government has always taken an aggressive and uncompromising approach to public service strikes. This sentiment coloured the research atmosphere and made migrant health professionals wary of any type of enquiry into their circumstances. The notoriety of the state intelligence services in the 1980s also fuelled this suspicion so that many respondents just wanted to be left alone to carry on with their lives without being "documented" by anybody.

Under these circumstances, sampling was out of the question and the researchers had to use "snowballing" techniques whereby some of the nurses and doctors assisted with the identification of their colleagues. It helped that some of the nurses and doctors were known to the researchers in various capacities. These links were useful in vouching for the academic nature of the research as well as its total independence from government sponsorship and patronage. In spite of these assurances, some of the nurses and doctors who were identified refused to be interviewed or to fill in the questionnaires given to them. The researchers had to make do with whoever was willing to participate in the research project.

The migrant nurses and doctors also took on partial exile identities and behaviours in that some of them felt they had been hounded out of their country against their will. Most were disenchanted with the situation in the health service, the state of the economy and polity, and the nature of politics in Zimbabwe. Being treated in the host countries like destitute exiles or refugees despite their skills was also an embittering experience and this partly explained why many of these respondents wished that things could change for the better in Zimbabwe to enable them return to the country.

The questionnaire was also used as a checklist to guide open-ended interviews and ensure the coverage of key topics in case the researchers had to resort to non-questionnaire data-gathering techniques and focus group discussions. This added a qualitative dimension to the research since it necessitated preparing the respondents for the discussion of the issues relevant to

the study, "bonding" with them over topics such as working conditions in the civil service and government-funded institutions, the pains of living away from home with spouses and children, the political and economic situation "at home", and the constraints and opportunities created by the SAP atmosphere in Zimbabwe. Some items of information were not amenable to collection by questionnaire, especially if the respondent was not personally known to all the researcher and research associates. Other types of information were left out because they could be easily obtained. For example, salary data were not difficult to work out since the nurses and doctors working in government service in Botswana and South Africa had incomes within known ranges. It was sometimes politic not to ask for such data in interviews if it could strain the interview atmosphere and alienate the interviewee.

In all, the primary data-gathering process in Botswana and South Africa was necessarily slow, even episodic given the issues being researched and the circumstances under which the doctors, in particular, had left Zimbabwe. As pointed out earlier, some left after strikes when it became clear that they were going to be involved in continuous confrontation with the government. All the respondents who co-operated with the study needed to be able to give the researchers their definitions of the situations in Zimbabwe, in Botswana and South Africa and what their reasons were for taking the decisions they did. There was a degree of trauma involved when professionals moved from their kith and kin to "uncharted" climes because they could not raise their children and pay for them in their country of origin. These feelings had to be accommodated in the methodology. As Schwartz and Jacobs (1979) observed, it was necessary to acquire "members' knowledge" and, consequently, to understand from the participants' point of view, what motivated them to do what the researcher had observed them doing and what these acts meant to them at the time. Such views could not realistically be gleaned through the questionnaire method alone. It became necessary for the research associates to share the worlds of the migrant nurses and doctors socially. This they did in different contexts, one sharing a house with some nurses over a university vacation and another interacting with doctors and their families between 1996 and 1997. The research findings were, thus, shaped by the experiences of the respondents, the research opportunities that arose, the methodologies best suited for tapping them, and the circumstances of all the researchers.

All but one of the nurses surveyed were in Botswana and all but two of the doctors in South Africa. There is also a gender dimension to the data gathered with all of the nurses, except one being female and all of the doctors, except two, being male. This segmentation of the migrant professionals by gender and physical location necessitates separate discussions, although in the subsequent sections of the report, the common themes that emerge from the study are pursued together.

Table 12: Characteristics and destinations of the nurses who responded during the study

Age	Gender	Marital status	No. of chn.	Date of migration	Destination
34	F	Married	2	1993	Botswana
44	F	Married	3	1994	Botswana
35	M	Married	2	1996	Botswana
35	F	Married	2	1994	Botswana
42	F	Single	4	1993	Botswana
50+	F	Married	3	1992	Botswana
46	F	Married	3	1992	Botswana
38	F	Married	3	1992	Botswana
41	F	Separated	3	1993	Botswana
38	F	Married	2	1994	Botswana
39	F	Divorced	3	1992	Botswana
40	F	Single	1	1994	Botswana
36	F	Married	2	1996	Botswana
35	F	Separated	2	1995	Botswana
30	F	Single	1	1994	Botswana
32	F	Married	2	1993	Botswana
34	F	Divorced	3	1994	Botswana
35	F	Divorced	3	1995	Botswana
30	F	Married	2	1991	South Africa
37	F	Widowed	3	1994	Botswana

No. of respondents = 20.

Source: Author's field survey.

As brought out in Table 12, the number of nurses who filled in a questionnaire and/or were interviewed is 20. 11 of the respondents (55%) are married, one (5%) is widowed, three (15%) are single, two (10%) are separated and three (15%) are divorced. All the respondents have children and only one is male. They all migrated to Botswana and South Africa during the first half of the 1990s after the SAP programme had started and they all gave financial reasons as the major factor pushing them to migrate. They wanted to buy houses, cars and earn foreign currency to finance the education of their children. They normally go on standard three year contracts that are renewable and they are all senior and specialised nurses with midwifery experience and, sometimes, other qualifications in theatre work as well as occupational and community health. All but three of the couples were physically separated by the migration strategy. Those nurses who were not living with their spouses said that this was due to the good jobs that their spouses held in Zimbabwe. It is also probable that the spouses were not likely to get well paid expatriate jobs in Botswana in their areas of expertise and this determined the migration strategy of the household.

The doctors were concentrated in South Africa and only two of the five who were said to be in Botswana were available to the researchers for

interview. Table 13 shows the characteristics and distribution of the doctors who were studied.

Table 13: Location and characteristics of doctors in the study

Age	Gender	Marital status	No. of Chn.	Date of migration	Destination
29	M	Married	1	1993	South Africa
30	F	Married	1	1994	Botswana
27	M	Single	0	1995	Botswana
30	M	Married	1	1991	South Africa
32	M	Married	1	1991	South Africa
36	F	Married	2	1987	South Africa
31	M	Married	0	1993	South Africa
38	M	Separated	2	1991	South Africa
34	M	Married	0	1994	South Africa
30	M	Married	1	1993	South Africa
28	M	Single	0	1993	South Africa
27	M	Single	0	1995	South Africa
28	M	Single	0	1993	South Africa
29	M	Married	1	1994	South Africa
39	M	Married	2	1987	South Africa
30	M	Married	1	1993	South Africa
28	M	Single	1	1993	South Africa
29	M	Single	1	1994	South Africa
31	M	Married	2	1993	South Africa

No. of respondents = 19.

Source: Author's field survey.

Twelve (63%) of the nineteen respondents are married and all but one of the married doctors have at least one child. Six (almost 32%) of the doctors are single and one (5%) is separated. Two of the doctors are female and both have migrated with their spouses and children.

All the doctors cited financial problems and the need to specialise as the major factors pushing them to migrate. The two doctors in Botswana cannot specialise because of the lack of training facilities for them in Botswana while all the doctors in South Africa have already specialised or are in the process of doing so. Most of the doctors would like to go into private practise on a full time basis but cannot secure full practising licenses in South Africa. Twelve of the doctors said they did locums and private jobs at clinics run by other doctors.

Analysis of Research Findings

The findings of this study need to be presented in the wider context of the situation prevailing in the health sector prior to the adjustment programme as well as during the reform implementation process. The situation report will be illustrated by describing the interviews with twelve health ministry personnel so that the migrant professionals' views can be understood in context.

The state of the Zimbabwean health sector

According to the Health Professions' Council, the number of nurses and doctors in Zimbabwe has remained constant with about 15,000 nurses and 1,200 to 1,300 doctors registering with the Council annually. These figures directly contradict the information from the Director of Nursing who estimated that Zimbabwe had, as of 1997, lost about 13,000 nurses and doctors due to the adjustment programme and the reduction in annual health spending which it brought about. She thought that every year, about 10% of the nursing resource base is lost. Most of the nurses migrate to Botswana, South Africa, the United Kingdom, and the United States of America. Table 14 shows the number of nurses and doctors registered with the Health Professions' Council.

Table 14: Number of doctors and nurses registered in Zimbabwe after independence

Year	No. of Doctors	No. of S.R.Ns	No. of S.C.Ns
1981	1,159	4,895	3,593
1982	1,211	5,220	4,239
1983	1,182	6,179	n/a
1984	1,250	6,179	5,054
1985	1,058	4,657	4,876
1986	1,342	4,980	5,151
1987	1,243	5,210	5,996
1988	1,201	5,487	6,468
1989	1,320	5,739	6,395
1990	1,519	5,976	n/a
1991	1,431	6,224	7,603
1992	1,474	6,337	8,223
1993	1,427	6,700	8,313
1994	1,457	7,367	8,016
1995	1,632	7,168	*

* Note that since 1995, SCN training has been phased out since all nurses are eventually expected to become SRNs.

Source: D.S. Bessant, Registrar, Health Professions' Council; Medical Faculty 1989; *Annual Review of Manpower* 1984.

From Table 14, it is clear that there has been considerable fluctuation in the number of doctors and registered nurses available for employment in public and private medical practise in Zimbabwe.

If the above figures are juxtaposed with those provided by the University of Zimbabwe about the number of doctors it has graduated since it started training doctors, it will be possible to draw inferences about the actual number of doctors and nurses in government employment at various points since independence. While the registration figures should not be taken as an accurate indication of the number of doctors and nurses actually in practise in Zimbabwe, they do indicate the potential figure of practitioners who had the intention of making Zimbabwe their work place at some point in their working lives. However, that potential is not being realised for many reasons which will become clearer as the discussion of the study's findings is presented. What is also important to keep in mind is the number of doctors employed in the government health system because it gives an indication of the kind of public health system that most Zimbabweans have access to during their life time.

Table 15 Medical doctors graduating from the University of Zimbabwe since 1980 (excluding non-Zimbabwean graduates)

Year	Africans		Europeans		Others		Total
	Male	Female	Male	Female	Male	Female	
1980	13	1	9	8	3	0	34
1981	10	1	25	2	3	1	42
1982	12	2	18	10	2	1	42
1983	0	4	41	3	5	1	54
1984	14	2	25	8	3	3	55
1985	25	4	12	5	6	0	52
1986	42	8	10	4	7	4	75
1987	42	10	5	1	8	5	71
1988	44	12	9	2	5	1	73
1989	39	7	0	3	3	1	53
1990	56	13	3	2	0	3	77
1991	53	11	0	1	2	1	68
1992	52	4	2	1	0	0	59
1993	40	10	0	1	1	2	54
1994	66	10	1	1	1	0	79
1995	50	10	0	0	7	0	67
Total	558	109	160	52	56	23	958

Source: Secretary, Godfrey Huggins School of Medicine, University of Zimbabwe, 1996.

Table 15 shows the total number of students who have graduated from the University as medical doctors since 1980. As can be seen from the table, the potential supply of doctors has increased dramatically since independence.

The medical school graduated 367 Zimbabweans between 1968 and 1979 and 958 Zimbabwean doctors between 1980 and 1995, an increase of over 200%. What has been problematic has been the retention of those doctors in the government-controlled health system.

With respect to nurses, according to the Secretary for Health, the number of SRNs graduated by the government between 1991 and 1995 stood at 2,900 as is shown in Table 16.

Table 16 SRNs graduating between 1991 and 1995

Year	Number of SRN graduates
1991	442
1992	422
1993	563
1994	712
1995	761
Total	2,900

Source: Secretary for Health. GoZ. 1996.

The table indicates the number of SRNs who, if retained, would have comprised between 25 and 30% of the SRN cadre of the country at present staffing ratios but it is clear that the attrition in the nursing side of the health sector has also been significant, thus making it difficult to approximate the ideal staffing ratio. The 1996 output of nurses and doctors was not available at the time this report was being completed because their training was interrupted by the industrial action undertaken by nurses and doctors between October and December 1996.

Medical doctors and their migration option

Mutizwa-Mangiza (1996) quotes *The Herald*, a daily newspaper in Harare, as saying that the Ministry of Health was in crisis by 1991 because the turnover rate of junior and middle level doctors was as high as 39%. From 1987, the University of Zimbabwe did not give doctors their degree certificates until they had served for two years in government service. But under pressure to liberalise the economy and democratise the polity, the government modified this policy by withholding only the practising certificates of fresh medical doctors for two years. With their degree certificates in their hands, many junior doctors opted to forfeit their Zimbabwe practising certificates by going to South Africa upon graduation to practise in those areas that are not serviced by the South African doctors. This led to the exodus of 50 to 70 Zimbabwean junior doctors per annum.

The advent of independence in South Africa in 1994 led to the removal of restrictions that prevented black South African doctors from practising in

some hospitals. This has had an impact on Zimbabwean doctors who are finding it more difficult to migrate to choice parts of South Africa. The attrition rate for doctors has decreased to 20 to 30 doctors per annum and these doctors are going to South Africa, Botswana and other countries outside Africa such as the United Kingdom. The priority that the South African government is giving to black South African doctors coming back from exile also makes it more difficult for Zimbabwean doctors to gain easy access to South Africa. The fact that expatriate doctors are normally posted to under-developed rural areas and the erosion of the value of the South African rand is also making South Africa less attractive as a destination for Zimbabwean junior doctors.

Profiles of two junior doctors

Dr X

Dr X is 29, male, married with one child. His spouse is a graduate. He completed his degree in 1990, started his internship in 1991 but left in 1992 before completing it. He was earning about Z\$2,500 a month at the time that he left. He was frustrated by the lack of professional progress because the hospitals had deteriorated and there were no opportunities for post-graduate study in Zimbabwe in his area of specialisation. He said he was living below the poverty line since he had a wife and a child and had no car or house. He does not know how long he will be away but he gave the impression of not being in a hurry to go back to Zimbabwe. He was assisted in his migration by South African friends of his who provided him with accommodation, food and moral support while he looked for a job and regularised his immigration status. He is presently in part time private practise, earning around R30,000 per month (Z\$65,000). His income is quite adequate for his needs while he pursues post-graduate studies.

He values his financial freedom, the opportunity to study under dedicated professors who have time to spend with him and their patients unlike in Zimbabwe where specialists are engaged in other business as transport operators, farmers, etc. The major worries he has are crime which is appallingly high and frequent. He has had a patient shot in his rooms and his car and money stolen. Racism is still rampant in South Africa and his family is isolated since very few of his relatives want to visit South Africa. He would consider taking residence and/or citizenship in South Africa given his experience of Zimbabwe. In South Africa, he feels that he can raise his child decently, his wife can study and there are opportunities that are open to him in a society where transparency is valued.

As far as Zimbabwe is concerned, he feels that nothing has improved enough to induce him to come back. If anything, he feels that the situation has deteriorated for government doctors in general and junior doctors in particular who need guidance, monitoring and training. He will only contemplate returning when he has enough money to buy a house, a car, furniture, and other necessities and when he can send his child to a good school and university. He said he was tired of struggling and relocating and until Zimbabwe has a stable government with good skills to run the country, there is no point in subjecting his family to Zimbabwe's conditions.

Comment

Dr X is one of the more disillusioned doctors who did not even wait to complete his internship before deciding to leave Zimbabwe. There was a strike while he was a junior doctor and the doctors who left in that year felt that the government was hostile to them and was convinced it could do without their services. Under these circumstances, these doctors did not feel safe in Zimbabwe and they chose to leave rather than to fight constant battles in which they could be victimized by being detained, deregistered, made to lose their pensions etc. The only option they could see was migration. Given the youth of this family, there was an incentive for them to migrate since they felt they had enough time to settle elsewhere. In Dr X's case, there was no specialist training in Zimbabwe in his area of specialisation so there was little additional incentive for him to stay on and struggle.

Dr Y

Dr Y is male, 31, married without any children. He qualified in 1989, did his internship in 1990-92, completed a specialist diploma in 1993, the same year in which he migrated. He was earning about Z\$3,000 when he migrated. He left because he did not think his career prospects in Zimbabwe were bright. His remuneration was just insufficient for supporting his family and he was not satisfied with what he was learning in Zimbabwe.

He expects to be away for five years. He was assisted to move to South Africa by friends who had already migrated. These friends informed him of job opportunities, gave him references, accommodation and moral support. He earns about R5,500 per month but considers that salary inadequate since the cost of living in South Africa is higher than in Zimbabwe and he has no family support. He does not anticipate renewing his contract since he planned his migration to be a short term measure. In the long term, he plans to make a career in Zimbabwe as a specialist.

He sometimes works as a locum to augment his income and he frequently comes in to work in Zimbabwe for a specialist in his area. He is able to remit money back to Zimbabwe since the Zimbabwean dollar is weak in relation to other regional currencies such as the rand. He says he is put off by the xenophobia in South Africa and the constant negotiations over permits with immigration in South Africa. He is homesick and cannot obtain full registration in South Africa where white foreigners are treated better than black foreigners.

He does not think his future in South Africa is bright. He feels that some things in Zimbabwe have improved enough for him to consider coming back. For example, he cited the openness of the economy and availability of consumer goods and better professional prospects for private practise as inducements for him to come back.

Comment

Dr Y has no children yet and is specialising in an area where there is an acute shortage of practitioners. He is in a predominantly white area of South Africa and probably is isolated and alienated by the racism amongst white South Africans and the xenophobia amongst all South Africans, especially the unskilled. His prospects in Zimbabwe are bright because he has already struck some rapport with a senior colleague in Zimbabwe who is doing extremely well in that specialisation. He is being closely supported by the senior colleague to complete his postgraduate studies. He also receives mentoring for the practical aspects of his specialisation. It is not surprising that he is well disposed to return.

In contrast, Dr X is probably lost to Zimbabwe for at least ten years. In his area of specialisation, there is no mentoring because the practitioners are so busy that they cannot do much else. Dr X has contacts with the black and white communities in South Africa and can mix well up to a point. He has a child who is about to start primary school and a wife who is keen to study further. Thus, his circumstances are such that the pull to Zimbabwe is weak.

Reasons adduced by medical professionals for leaving Zimbabwe

Nurses

The career path of Zimbabwean nurses comprises three years' training after Ordinary (O) or Advanced (A) levels in the school system. According to the Director of Nursing, doctors and nurses leave Zimbabwe because the conditions of service are not very good. The salaries tend to be very low compared to those in Botswana and South Africa. Even after the salary review

of 1995, the nurses obtain Z\$5,000 for car loans which can only help them purchase second hand cars. They did not get any bonuses as of 1995 and both doctors and nurses are overworked because of the understaffing and under-equipping of health institutions. Compared to the urban council clinic nurses who work eight hours per day, government nurses work longer hours with 11-hour night duties. As to rural nurses who are frequently called upon to help sick people even after the clinics have closed officially, they virtually operate a 24-hour duty routine. For being officially on duty overnight, nurses earn a paltry Z\$10 bonus.

According to the Director of Nursing, the most mobile nurses are the single, newly qualified junior nurses who are around 22 to 23 years of age. She had the impression that many young nurses leave to go abroad as soon as possible after training so that they can quickly accumulate their material requirements such as cars and money after which they can come back to get married around the age of 26 or 27.

The nursing promotion hierarchy and pay structure prior to 1992 when the adjustment programme was launched is summarised in Table 17.

Table 17: The nursing structure and pay scales prior to 1992

Grade	Salary per annum in Z\$*	In US\$
Student nurse	20,104	4,020
State Certified Nurse	28,335	5,667
Jnr Sr/State Registered Nurse	35,835-37,500	7,167 -7,500
Snr Sr (after two years)	37,500-41,665	7,500 -8,333
Sister in Charge	43,335-52,500	8,667-10,500
Matron Grade 3	45,835-60,835	9,167-12,167
Matron Grade 2	63,335-70,835	12,667-14,167
Matron Grade 1	71,500-75,835	14,300 -15,1

*The US\$ was equivalent to around Z\$5 by mid- 1992

Source: Ministry of Health.

After strikes and unrest by nurses and junior doctors, civil servants' salaries were revised in 1995 to give all nurses a 20% salary increment which resulted in the new salary and grading structure presented in Table 18.

Table 18: The nursing structure and pay scales in 1995

Grade	Salary per annum in Z\$ ¹	In US\$
Student nurse	24,000	3,000
State Certified Nurse	34,000	4,250
Jnr Sr/ State Reg'd Nurse	43–45,000	5,375–5,625
Snr Sister (after 2 years)	45–50,000	5,625–6,250
Sister in Charge	52–63,000	6,500–7,875
Matron Grade 3 ²	55–73,000	6,875–9,125
Matron Grade 2	76–85,000	9,500–10,625
Matron Grade 1/Princp. Nurs. Off.	69–95,000	8,625–11,875

Assistant Director of Nurses and above operate at Ministry level.

¹The US\$ was equivalent to Z\$8 by mid 1995.

²Senior Nursing Officer if male.

Source: Ministry of Health.

After the 1995 salary review, the nurses' retention allowance of 20% which was tax and pension free was phased out. With the underfunding of the public sector, benefits such as free medical treatment for all health personnel in public institutions also began to be eroded. Now the health workers have to pay for their drugs. Furthermore, the erosion of the buying power of the Zimbabwe dollar has affected nurses' salaries

The salaries in Botswana, the destination of choice for many nurses from Zimbabwe, were at least three times as high as those in Zimbabwe and the conditions of service much better. The nurses in Botswana had access to drugs, gloves, masks and modern equipment for use in patient care. Even after the 1995 salary review, nurses found that they could still earn much more by going to Botswana. The 1997 strike by nurses and junior doctors highlighted some of these issues.

Junior doctors

The situation for junior doctors is, in many ways, similar to that of the qualified nurses. Junior doctors employed in public hospitals and institutions are traditionally overworked since they are at the bottom of the totem pole in their profession. They also try to supplement their incomes through assisting in private surgeries that are owned and run by senior doctors. Their career path in the Zimbabwean health system is, according to them, very long. A student enters medical school and studies for five years after which the student has to undergo house training for two years. In Zimbabwe, a new doctor has to serve in a designated hospital for a year before he/she can even contemplate specialised training. Thus, some junior doctors prefer to go to South Africa or overseas to specialise or undergo post-graduate training immediately after qualification.

For many doctors, it is not very appealing to work in government hospitals because there are acute drug, equipment and supporting staff shortages in such institutions. For example, in 1994, Harare Hospital had only one type of antibiotic available and the hospital was already into its October budget as early as March of that year. Mpilo Hospital in Bulawayo has a renal unit which by January 1996 was appealing to the public for funds to care for its kidney patients. The Minister of Health suggested excluding AIDS patients from dialysis as a cost-cutting measure. Gweru Hospital, like other hospitals, was experiencing food shortages by November 1995 and visitors were being asked to bring patients home-cooked food. The hospital was also appealing to the public for food donations.

Given the high HIV prevalence in Zimbabwe, nurses and doctors risk their lives when they have to handle patients, as was increasingly the case, without essential equipment such as gloves, masks and other protective devices. Many of them consider the remuneration which they get as being too small relative to the risks that they run in the line of duty.

The state of the morgues is another issue that merits being described because it gives an indication of the deteriorating situation of the health infrastructure in Zimbabwe, a deterioration which is a factor influencing the migration decision of doctors. Parirenyatwa Hospital was built in the 1970s as a whites only hospital and had state of the art equipment and facilities. According to the 7th to 13th March issue of *Sandawana News*, a weekly paper, the morgue that services the 1,500 bed hospital was designed to take 42 bodies but now takes 200 plus bodies and has a lingering smell because of decomposing bodies. According to Mr Tabvemhiri, the morgue supervisor, morgue staff do not have the necessary chemicals to disinfect the place. The government has no money and morgue maintenance is not deemed a priority area for expenditure. The morgue supervisor has worked in the morgue since 1972 and he said that during the colonial era, morgues had freezers to preserve the bodies after death. Now they only have cold rooms.

Harare Hospital, formerly a low income blacks only hospital, has a morgue initially designed to take 60 bodies but now takes over 200. Mpilo Hospital, also formerly a low income hospital reserved for blacks in Bulawayo, has a capacity for 100 bodies but now takes 300 plus while Mutare Hospital's morgue was designed for nine bodies but now takes over 20 bodies. Given that morgues carry more bodies than was originally intended, especially as the hospitals were de-racialised after independence and were permitted to admit people without restriction, and also given the fact the country's population has grown significantly since the 1970s, many bodies are decomposing before they are collected for burial. Bodies are sometimes placed on the morgue floor when all the spaces and gurneys are full. This treatment of human remains was deemed demeaning and distressing by the morgue

supervisor who thought that it showed lack of respect for ordinary people's lives.

Harare hospital's morgue is in the worst condition because, being the main health facility for low income patients, many paupers are taken there and lie unclaimed for up to three months before being given paupers' burials. According to the Secretary for Health, in November 1996, there were 284 paupers' burials and 478 people brought in dead by the police to government hospitals. These people, together with those who die in hospital have to be held before burial in government morgues which are overcrowded and unable to cope with the numbers of bodies. Thus, the capacity to handle the dead and the living in government hospitals has been severely compromised.

Table 19 summarises the salary for government doctors as at the beginning of January 1997. Apart from their remuneration, doctors are entitled to a Z\$50,000 loan in order to purchase cars but they complained that this had been abused by corrupt health officials who made the loan available only to senior doctors rather than the juniors. The 1.6% allowance that doctors used to get over their salaries is now subject to tax and pension deduction following the 1993 salary increment.

Table 19: Salary scales for government doctors in 1997

Grade	Salary in Z\$*	In US\$
Secretary for Health	133,476	13,347
Head of Dept/Specialist	126,876	12,687
Senior Resident Medical Officer	97,896-120,276	9,789-12,027
District Medical Officer	97,896-120,276	9,789-12,027
Junior Resident Medical Officer	97,896-109,896	9,789-10,989
Medical Officer of Health	120,276-123,564	2,027-12,356
4th Year Cadet	24,276-26,136	2,427-2,613
3rd Year Cadet	26,136	2,613
2nd Year Cadet	20,820-26,136	2,082-2,613
1st Year Cadet	18,516-26,136	1,851-2,613

*The US\$ was equivalent to Z\$10 by the end of 1996.

Source: Ministry of Health.

Information obtained from health professionals who were interviewed suggests that even the Secretary for Health who is a doctor, is disadvantaged in comparison to other high ranking civil servants such as the Head of the Public Services, the Commissioner of Police and the Chief Justice who all have a government-guaranteed entitlement to houses, guards, and Mercedes Benz cars. In the Ministry of Health, the Permanent Secretary does not even have a house comparable to the type allocated to his colleagues in other ministries. Instead, he lives in a house that is meant for the Superintendent of Parirenyatwa Hospital and drives a Mazda 626.

The junior doctors working in the public hospitals also feel neglected because as an increasing number of senior doctors leave for private practise,

the former no longer get adequate instruction, training and supervision and have to work even longer hours to make up for the shortage of senior doctors. The deplorable situation with equipment in the public sector in Zimbabwe also disadvantages junior doctors since they cannot keep abreast of new developments in their field. Thus, the inadequacy of accommodation, remuneration, transportation, and mentoring all result in gross and acute dissatisfaction amongst junior doctors, contributing to the decision by some of them to migrate.

All the junior doctors in government practise who were interviewed complained that the conditions of work in the civil service are deplorable. The doctors argued that they were underpaid and overworked in a system that is inefficient and impervious to any new idea that reflects adversely on the existing situation. One doctor had this to say about the reasons why some of them stayed for a few years in government service:

We are working because we want to specialise and we have to put in the required two years, one as a house officer, another one to obtain your Open Practising Certificate and the third year in government service before you can go into private practise or specialise here. What is making some of us stay is the problem of obtaining sponsorship to specialise outside Zimbabwe. I am attached to the department that deals with my desired specialisation and I am acquiring experience so that I enhance my chances of getting good references and training in that area. We are all instrumental in government service.

On the conditions of service, there was a general consensus among people who were asked for their comments as patients, doctors, nurses and taxpayers that government hospitals have been in a bad state for at least five years and that the situation deteriorated even further after the 1996 strike. One doctor spoke about the shortage of equipment in his area of specialisation:

We use old equipment which is in bad shape. We are supposed to have equipment to examine adults and children but we do not have the children's equipment so we just use the adult equipment on them. It is bad. (Name and specialisation withheld.)

Another doctor said:

There has been a shortage of staff for the last ten years and this is getting worse. Now, we do not have enough nursing staff and some wards will be closed in February, 1997. Patient care has been compromised in the last decade. The morale of the doctors is low but that of the nurses is worse. You just have no idea how bad things really are.

Regarding the morale of nurses and their working conditions, a group discussion which was held with nurses revealed that many of them feel that they just cannot cope any more because of the underfunding of the health

sector, the underpayment of health workers, and the corruption and lack of professionalism in the health service. A senior nurse had this to say:

There are many reasons for the present situation. There is poor remuneration, erosion of professionalism, corruption in promotions and illogical career paths in the nursing structures. These all result in the wrong people being promoted and bad performance and lack of accountability on the job.

She cited instances where people were promoted above their competencies and could not perform the jobs. She argued that there is a lot of corruption in promotions so that even when competent people are in the system, they are sometimes overlooked and sidelined while incompetent but well connected people were appointed. In one of the cases she cited of an incompetent person being appointed into a senior position, the person eventually resigned after causing chaos, experiencing insubordination from junior staff and generally bringing the whole structure into disrepute. She indicated that the previous incumbent in the job had been very competent, strict and good at supervision so it was possible for the hospital to continue to provide a reasonable service even in the face of budget cuts. The new incumbent had no supervisory experience and did not even know what equipment was available. In the event, many services were not offered and patients were told that dressings and packs were not available when in fact there was a storeroom full of all the necessary equipment which the senior person did not even know existed. Thus, the hospital's service suffered and nurses were able to get away without working as much as they could because the senior person did not know her job and its responsibilities.

The issue of accountability was raised by both doctors and nurses who were generally agreed that the breakdown in the system, particularly at the top, allowed people to evade responsibility and accountability. One junior doctor said:

Many jobs are not done and people will not be accountable or accept responsibility. Everybody blames the system, the lack of medicines, antibiotics, bandages etc. In my area, we often do not have dressing packs or sterile gloves. We use unsterile gloves to do whatever dressings we can. This compromises the health of our patients and our operation results. We are exposed to infection because we recycle unsterile and old equipment. For example, during operations, there is the risk of accidental blood spillages through lack of proper equipment. In the medical wards, there is a higher incidence of tuberculosis but we have no masks. Doctors and nurses have to attend to patients without the masks. We do the best we can in the circumstances. I feel depressed when I cannot do the best for my patients. Sometimes they die when they should not have died.

The same doctor was of the opinion that because the government has allowed the health system to become grossly underfunded and the staff badly paid, it has opened the door for medical professionals to become unprofessional

because everyone agrees that the system is badly funded and everything is blamed on drug, staff and other resource shortages. According to this doctor,

You blame everything on the system even when you are negligent. Even where the system works, you can argue that it does not and get away with it because now there is a consensus that it does not work. Those responsible do not want to have to enforce any standards under these circumstances. There is better medicine in the private sector now than in government institutions.

The sentiments expressed by the doctor were confirmed by the Secretary for Health whose view was that in the first instance, it is necessary to halt the deterioration in the health system before it can even be turned around. His view was that the management of the health system left a lot to be desired so that even those resources that existed were not properly deployed and the institutions run as well as they could be.

Government responses and interventions

According to Ministry of Health officials, the salary review of 1995 was one of the major attempts to deal with the dissatisfaction shown by health professionals with their remuneration and conditions of service. In addition, district hospitals are now accommodating not only student nurses but some qualified personnel as well. Chinhoyi, the newest hospital, has flats for all personnel who need to stay near the hospital and at most hospitals, construction of high quality urban-type subsidized houses and flats is under way in order to accommodate doctors and nurses. Doctors also have access to Z\$50,000 car loans and the ministry now provides transport for junior doctors to move from Parirenyatwa to other Harare hospitals as required by their duties.

The number of nurses at all hospitals is being increased so as to reduce the working hours of nurses in the public service. According to the Secretary for Health, another 1,684 posts have been approved for SRNs in the provinces so that the workload of the nurses in the system can be reduced. This is to be achieved by offering employment to every nurse who has been trained. Nurses now have the choice to apply to hospitals according to their individual preferences.

The Minister of Health has tried to negotiate with the governments of Botswana and South Africa to stop them fuelling the brain drain by recruiting medical professionals from Zimbabwe. Instead, South Africa was being asked to recruit doctors from Cuba. However, these negotiations do not seem to have had any impact on the recruitment of Zimbabwean health professionals because, as late as July 1996, the researcher met newly recruited nurses from Harare in Botswana and these nurses were of the opinion that the migration of health professionals was not likely to abate unless the government of

Zimbabwe changed the terms and conditions and remuneration of health professionals in Zimbabwe. The governments in the neighbouring countries also argued that they respected human rights and, therefore, were not in a position to interfere with the individual decisions of medical professionals to work wherever they desired.

Pull Factors Encouraging the Migration of Zimbabwean Health Professionals

Thus far, the report has dealt with the push factors that encourage individual medical professionals from Zimbabwe to migrate to Botswana and South Africa. It is necessary to examine those factors that attract Zimbabwean doctors and nurses to South Africa and Botswana, the pull factors.

The nurses and doctors who migrated did not experience major problems in securing information about migration procedures and working conditions in the neighbouring countries. These countries advertise their jobs and, in the case of nurses, health officials from Botswana usually come to Zimbabwe to interview candidates for jobs. There is also a very active grapevine about job possibilities in South Africa. Generally, doctors were in touch with other doctors who had migrated first and they were able to secure accurate information about vacancies. There were no problems of accommodation, transport and other services because all these were provided by the governments which recruited the doctors and nurses. The doctors were able to arrange references for their colleagues and to keep them informed about opportunities in specific institutions as they arose.

It is important to note that when the initial group of doctors left for South Africa in the wake of the 1988 strike, there was a strong sense of betrayal which was felt across the board by the junior doctors. This bonded them in many ways and built up some cohesiveness amongst them which would not have arisen without the experience of being denounced by the politicians and, for some, threatened with imprisonment and the termination of their appointments. These events have repeated themselves in the subsequent strikes culminating, in 1996, in job losses for about 300 nurses and two doctors. The doctors and nurses were accused of fomenting the 1996 strike and were struck off the register.

The countries of destination of medical professionals from Zimbabwe

It is worth recalling a point which was made earlier in the report, namely that the market for medical professionals outside Zimbabwe is segmented. Nurses tend to migrate to Botswana because there is a shortage of trained and experienced nurses in that country. The recruiters from Botswana come to Zimbabwe to interview and recruit nurses in the different city hotels within Zimbabwe. The Botswana government provides the newly recruited employees

with hotel accommodation in the first month of work during which the nurses make arrangements for longer term accommodation. Botswana is within monthly commuting distance for many nurses with families in Zimbabwe and so, it is a very convenient destination for them.

Botswana is not a very attractive destination for junior Zimbabwean doctors because it does not have a medical school. There are no prospects for post-graduate study and training and there is very little money to be made in private practise given that the public health system is still well funded and run by the Botswana government. There is not a large enough pool of private patients to provide private practitioners, particularly expatriate junior doctors, with a lucrative living in Botswana. Therefore, many junior doctors choose to migrate to South Africa and overseas. The next section of this report deals with the actual responses of the doctors and nurses who were interviewed and surveyed in South Africa and Botswana.

Responses from nurses in Botswana

Contrary to what the administrators in the Ministry of Health assumed, the Zimbabwean nurses who migrated to Botswana range in age between 29 and 44 years. They are mostly female and, according to our respondents, in the whole of Botswana, there were only five male nurses at the most. The majority of Zimbabwean nurses in Botswana are married. This is because the private hospitals in Botswana require the services of nurses who are skilled and experienced in special fields such as theatre, anaesthetics, intensive care, midwifery and other specialised areas. Obtaining the necessary qualifications for these special fields involved three to five years of additional post-graduation study. By the time most nurses completed these courses, they were usually either married or got married soon after. The average number of children among the migrant nurses surveyed was three.

The nurses mostly had well-qualified and well-paid husbands who included university professors, company executives, teachers, successful artisans and directors. Although their husbands held well paid jobs, the nurses migrated to fulfil their desire to be independent and financially self-sufficient. All the nurses were State Registered. At the time most of them left Zimbabwe between 1990 and 1995, they were earning between Z\$1,800 and Z\$2,600 per month. In Botswana, State Registered Nurses were earning the equivalent of Z\$10,000 per month (about US\$ 1,000) whereas if they had stayed in Zimbabwe, they would be earning about Z\$50,000 per annum which would translate to Z\$ 4,166 per month (about US\$ 416 per month). During the time this research was being carried out in 1996, the exchange rate was Pula 3,3834 per Zimbabwe dollar; the Zimbabwe dollar has depreciated even more since then.

The most common career trajectory amongst the nurses was that after completing their training in Zimbabwe, they initially worked as State Registered Nurses and Senior Sisters in various health centres across the country. They only decided to move to Botswana from the early 1990s when the Zimbabwe dollar started sliding downwards to a point where they could no longer sustain their families' food and everyday requirements. It should be pointed out that in many Zimbabwean households, the women are responsible for buying food and clothing for the household, paying the wages of the domestic worker, meeting the personal requirements of the children, including toys and entertainment, and handling other household consumption requirements regardless of the earnings of their husbands. Husbands normally take care of mortgage payments, education fees, car purchase/maintenance bills.

Thus, in the 1990s, particularly with the onset of adjustment, many wives found themselves unable to realise any discretionary incomes and savings after fulfilling their parts of the marital bargain. The prices of food, drugs, clothes and other necessities consumed by households rose steeply and women's incomes could not cope. Thus, the economic situation eroded the power balance between spouses, especially in professional households, as the wives lost savings and could not mobilise or use company benefits for provisioning households. This contrasted with the situation of many of their husbands who, as company executives and other types of professionals, had access to perks such as cars, housing, children's school fees, the use of company holiday facilities, and entertainment allowances.

Below are the biographies of two nurses showing the direction their careers and lives have taken, their responsibilities and coping mechanisms.

Nurse A

She is in her mid-thirties, married with two children and a spouse with a top level job in Zimbabwe. She completed O levels in 1982 and started her training as a nurse in 1983. She worked as a civil servant from 1983, beginning as a trainee. In 1991, she did her midwifery training in a government hospital. She resigned as a senior sister in 1993 with a take home pay of approximately Z\$2,000 per month. She migrated in May 1994 because she wanted to make ends meet. She had siblings to support because her parents were dead and she needed a car of her own since the car they used in the family was her husband's company car.

She expects to be away for six years. She was not assisted by anybody in her migration since the Botswana government advertises and interviews in Zimbabwe for civil service jobs in the health sector. She now earns about Z\$11,500 per month in Botswana. Her salary is quite adequate for her to live

on in Botswana since she shares a house with some nurses. She says she can afford to pay rent for herself and for her siblings in Zimbabwe, buy groceries and other consumer goods. She has become quite comfortable financially since she migrated and she does not need to indulge in other income-generating activities in Botswana. Her life has changed since she can pay her bills unlike in Zimbabwe where, she says, her life was a constant struggle to stretch money to the end of every month. As part of that struggle, she found herself having to buy small things to sell in order to generate extra income.

In Botswana, she says that she has paid for her financial comfort by losing her political voice since she cannot vote locally or decide anything to do with Zimbabwe's health policy from her base in Botswana. She dearly loves Zimbabwe but cannot stand its doctrine and practise of "beggaring" all the working professionals. She feels that conditions in nursing have become worse since she migrated and it does not look as if things will improve for some years to come. She wishes that the Zimbabwean government could introduce a car loan scheme such as the one in Botswana to allow people to commute to work in a dignified manner. In Botswana, every professional can acquire a car loan after one month of working and this is a good incentive for nurses to stay in government service. She misses her children and spouse and that is the only issue that really makes her unhappy. She feels that the price for the "survival" of her siblings has been the separation of her family which is also the fault of the government for making it impossible for her to be with her family while taking care of her siblings.

Comments

The case of nurse A shows her need for discretionary income for the upkeep of her siblings for whom she is responsible, especially as her parents have died. She cannot, in patrilineal practise, expect her husband to finance their upkeep. Thus, she has to have extra income which is not perceived to be her husband's. The fact that her husband has agreed to her working as a migrant was considered very unusual by her friends. She spends a lot of her days off and holidays commuting to Zimbabwe to be with her family. Once some of her siblings start working and helping her with the younger ones, she plans to come back to Zimbabwe. She definitely felt that she had gained some ground in her marital relationship by her ability to bring in foreign exchange and to finance some of the children's needs and buy her own car. There is, of course, the problem of possible infidelity on her husband's part since in Zimbabwe, men's infidelity is socially tolerated especially if a wife chooses to work away from the home to escape disempowerment in the marriage associated with heavy dependence on a husband's income.

Nurse B

She is a woman in her early forties who is single with four children. She has her O levels and is a trained SRN. She started working for government in 1984 and remained in government service until 1991. She migrated in 1993 when things were "really bad" in government service. She expects to be away from Zimbabwe for 12 years. She did not need much assistance to migrate since she applied to the Botswana government for a job and got it. She sponsored herself to go and was temporarily accommodated by friends who had already migrated to Botswana. At present, she earns about Z\$11,500 per month and she finds this salary adequate for meeting her needs, sending her children to school and saving for the future. The Botswana pula is a strong currency and enables her to afford many consumer goods in Zimbabwe where some of her children go to boarding school. The income tax on Pula (P) 2,760 is only P88 per month, which is negligible compared to Zimbabwe where one pays at least one third of one's salary in income tax every month.

In Botswana, there is a problem of lack of incentives since the country is so sparsely populated and lacking in training and continuing education institutions or specialist nursing programmes. The locals are hostile to African expatriates since they have historically depended mainly on western expatriates. She has no intention of taking Tswana citizenship despite her plan to stay for a long time in Botswana. She cannot go back to Zimbabwe because the health service has actually deteriorated since she migrated. Unless salaries are raised and pegged to inflation, income tax is reduced dramatically, government offers loans for cars, houses and other large items, reduces school fees, improves the quality of education and makes scholarships for further training available to all who qualify, she does not think that she can contemplate returning to Zimbabwe. She asked the researchers:

Is the Zimbabwean government aware that this migration to other countries is a disgrace? There is no one who wants to work for other nationsWe encounter a lot of frustrations but due to good salaries, (we) bear them until we achieve what we want...The ill-treatment of poor immigrants is just unbearable. Can't the government create jobs for such people in Zimbabwe? Zimbabwe is a beautiful country but is being destroyed by regionalism.

(The reference to poor immigrants stems from media reports of the rough-handling of Zimbabwean job seekers in Botswana.)

Comments

Nurse B is a single parent with four children to put through school. She has to stay in Botswana on a long contract because of her responsibilities towards her children. She could not support them on her salary in Zimbabwe and her

present comfort level has to be maintained. She feels she is marooned in Botswana where Zimbabweans are subjected to xenophobia. She has worked hard in her life and feels that she cannot even access further training in Botswana, a price she has had to pay for the economic security she enjoys in the country. Her sense of being let down by her government came through very strongly in the interview and she is embarrassed by the way Zimbabweans lose their dignity by leaving home to live as migrants, grovelling for residence permits and having to witness the roughing up and crude handling of Zimbabweans who are caught while residing and working or seeking work illegally in Botswana.

Nurse B gave the impression of being doubly let down, first by the Zimbabwean government which could not afford to pay its professionals decent salaries and secondly, by being looked down upon by foreigners less qualified than she was. In Botswana, most respondents referred to the xenophobia they experienced from locals who had inferior or no skills but who felt that Zimbabweans were a desperate lot if they had to leave their homes to work in a foreign country. In addition, the disempowerment that black foreigners feel in relation to their white western counterparts in Botswana adds another dimension to the alienation of Zimbabwean medical professionals in Botswana.

Assessing the experiences and conditions of the migrant nurses

In the marital politics of most households like those of the nurse respondents in this study, the company benefits enjoyed by senior male executives provided safety nets for the husbands who were better able to continue to uphold their side of the marital bargain, namely, to pay for the children in expensive schools, take them on holidays annually, provide transport for the families on a daily basis and pay the house mortgage. Thus, because husbands are cushioned by company benefits even in times of economic stress, husbands can actually increase their marital power and influence during these times precisely because the women's earnings are not protected in government employment. Thus, the additional stresses of provisioning relatives and kin, contributing financially to the marriage, and reducing income disparities impelled some professional women to migrate and leave their husbands and children in Zimbabwe.

The nurses were also keen to escape what many saw as the "punitive" 30% income tax rate on their paltry earnings in Zimbabwe. In Botswana, on their approximately P3,000 per month earnings, nurses pay only about P 80–90 in income tax, a rate of under 3%. In Botswana, the nurses had access to offshore banking services and were given very easy terms to purchase cars. Thus, after a month's work, a nurse can buy a good quality car. Most of the nurses

wanted foreign currency to finance their children's education overseas if necessary. Since most companies do not pay for tertiary education for adult children, the nurses were cognisant of the need to prepare for their children's tertiary education especially given the fact that this education might have to be undertaken outside Zimbabwe. Moreover, there has been acute inflation in university entry qualifications in Zimbabwe so there is no guarantee that most children who pass their A levels can ever study in Zimbabwe. The announcement by the Minister of Higher Education that as from 1997, students would have to pay 50% of their university fees has exacerbated the situation. It is even more imperative for parents to have cash in hand if their children are ever to access tertiary education in Zimbabwe.

Although some nurses continuously renew their three year contracts, the majority expressed the intention to return to Zimbabwe after working one or two contracts. Whether such intentions can actually be realised in the worsening economic climate in Zimbabwe is a moot point. Although most of the nurses say they are materially satisfied, they are apprehensive about their marriages and children in the context of the HIV threat. They are afraid that their marriages will be negatively affected by their absence, that their children will be neglected since, culturally, women are supposed to be the child carers in Shona and Ndebele societies, that their husbands will consort with other women during their absence and expose them to the possibilities of contracting HIV, and that they might be criticised by their friends and relatives for deciding to migrate for work. The nurses said they just wanted to pay back their car loans and rush back to their families in Zimbabwe.

Some of the migrant nurses used informal contacts to obtain information about work in Botswana. They applied to the Botswana government for employment and sponsored themselves financially to migrate. None of the nurses undertook any other forms of income generation to improve their livelihoods in Botswana; their salaries were high enough to cover their needs and leave room for savings.

Problems encountered by nurses working in Botswana

Working as immigrant nurses in Botswana has its problems for Zimbabweans. Because of the language differences, most nurses face language and communication problems in the workplace and in their social lives. Expatriates from black countries tend to be disempowered both within and outside the workplace such that they cannot participate meaningfully in shaping policies and practises that affect them. They face hostility and intolerance amongst local people who look down upon them for coming to work in their country. They are often told that they are beggars or destitutes and that they have should not expect any respect since their countries cannot offer them

employment. These problems are common to migrant workers all over the world and xenophobia tends to be exaggerated during times of economic hardship.

There is also a problem of security of possessions as the rate of burglary is rising. Nurses complained that they have to spend their money on security for their cars and other property. Professionally, many nurses, like Nurse B, complained about stagnation since they cannot take part in any kind of continuing education and training in their field in Botswana while they are working on contract.

According to all the nurses, the information available to them suggests that the conditions of work in Zimbabwe have actually deteriorated what with drug, staff and equipment shortages and the removal of the annual bonus. They, however, acknowledged the improved availability of goods that were previously unavailable in Zimbabwe. They cited the following as some of the conditions that would have to change to induce them to return to Zimbabwe sooner than they planned:

- 1) Better working conditions in hospitals, including more adequate safety equipment for handling patients;
- 2) Significant increases in nurses' salaries;
- 3) A more realistic income tax rate;
- 4) Reasonable car loans and other perks for nurses.

Most of the nurses' views could be summed up in the words of one of them, Nurse B, who said:

Is the Zimbabwe government aware that migration is a disgrace? There is no one who likes to work for other nations but circumstances have forced us. We encounter a lot of frustrations but due to the good salaries we bear it until we achieve what we want. Ill-treatment of the low income migrants by the Tswanas is just unbearable. Can't the government create jobs for such people in Zimbabwe?

Another nurse had this to say:

Why should I work for a low salary in conditions that expose me more to HIV when just across the border I can work with good safety equipment for more money? Why should a special person like a nurse or a doctor use an E.T.(emergency taxi. In Zimbabwe, emergency taxis are usually ramshackle, dangerous and uncomfortably overloaded) to get to work together with the patients she'll treat?

These statements aptly encapsulate the feelings of embarrassment and powerlessness that migrant nurses experience both within and outside Zimbabwe since as professional people, they have to put up with discomfort, uncertainty, insult, frustration and eroded relationships with spouses and children whether they stay or leave to work in Botswana. According to their

professional oaths, nurses are not supposed to go on strike or neglect patients in the process of expressing their grievances. Under such circumstances, it is not surprising that they leave the profession in large numbers or migrate to other countries where they can work as nurses under better conditions.

Migrant doctors in Botswana and South Africa

As noted earlier, at the time the research was conducted, there were five Zimbabwean doctors in Botswana and only two agreed to be questioned. The others cited fear of political victimisation in Zimbabwe as the reason why they were reluctant to be interviewed. The two doctors who were interviewed left Zimbabwe because the salaries in the country were unsatisfactory. Their Zimbabwean salaries averaged about Z\$ 2,500–\$2,700 per month at the time they left while their salaries in Botswana were at least five times that much at about P4,000 per month (S12,000) per month or US\$1,200 per month. Although their salaries were generous in Zimbabwean terms, the doctors felt that they were not adequate enough to allow them to save because food and accommodation are expensive in Botswana. None of the doctors looked forward to renewing their contracts because they felt that in Botswana, they were stagnating professionally. There is no medical school in Botswana so any professional and post-graduate advancement would have to take place elsewhere. The doctors were not involved in any other income generating activities in Botswana.

For the doctors in Botswana, migration served their immediate short-term goals of buying cars and furniture, paying children's school fees and saving for the purchase of their houses in Zimbabwe. They felt that things had not improved significantly in Zimbabwe for them to contemplate going back. None of them considered taking up citizenship in Botswana. They were of the opinion that better salaries, easier credit and lower taxes would go some way towards making them consider going back to Zimbabwe. In Botswana, the doctors said they felt hated, unappreciated and resented since the locals tended to consider and treat them as insensitive fortune seekers.

The 17 doctors South Africa-based Zimbabwean doctors who were interviewed for this study also said they had left as a result of the dissatisfaction with their salaries in Zimbabwe and the unfair treatment meted out to them by the Zimbabwe government especially after the 1992 industrial action. Like the doctors in Botswana, they are relatively young, between 27 and 33 years of age. In South Africa, they have been able to go into government service, post graduate study and extra work as locums in the private surgeries of established doctors in South Africa. In addition, their children were able to attend good public and private schools while their spouses furthered their education in universities, technikons and other colleges for tertiary education.

Thus, financial difficulties and untenable working conditions in Zimbabwe were the major reasons for migration among the doctors. The issue of financial difficulty is very important in the context of the lifestyles doctors have traditionally expected to adopt after graduation. In 1992, the take home pay of the average junior doctor was about Z\$2,000 (about US\$ 250) per month. This figure came up consistently in the interviews with doctors. At that time, the rent for an apartment with one bedroom was about Z\$900 per month in the lower income part of the city. Given that the average junior doctor was married with at least one child, there was a problem of getting by, even on two salaries, after the rent had been paid. The marriage patterns in Zimbabwe show that men tend to marry women who are less accomplished than they are in education, income and professional standing. Male doctors tend not to be very different from other men in this regard.

Assuming that the junior doctor's wife, usually a nurse, teacher or secretary took home Z\$1,200, the combined salaries of the couple would amount to Z\$3,200 per month. After rent, electricity, water and related utilities had been factored in at around Z\$1,200, the couple would be left with Z\$2,000 to pay for food, transport, the childminder's wages, clothing and other expenses. The minimum wage for domestic workers in 1992 was about Z\$200. The monthly food basket for a middle income couple with one child under five, on the basis of the Consumer Council's consumer price index in 1992, would amount to about Z\$1,000. That would leave the couple with just Z\$800 to pay for transport, lunches and their other expenses such as health, education, telephone etc. During the 1980s and 1990s, most junior doctors did not have enough money to purchase a used car. A ten-year old, 1300 c.c. car retailed at around Z\$16,000. This was beyond the reach of the ordinary couple in government service.

Thus, junior doctors depended on hospital or public transport to get to work in the mornings or to go on calls. Since hospital accommodation was scarce, many doctors had to find housing on the open market. Thus, the ordinary couple spent at least Z\$4 per day each on commuting costs. This meant that a couple could expect to spend between Z\$160 to Z\$200 per month on transportation. That would leave them Z\$480 for lunches, medical care and probably, remittances to family and kin, siblings' school fees and medical care. Clearly, with the hospitals not providing medical care for employees, the costs of prescription medicines, especially for couples with young children who catch colds, coughs and related diseases, can be quite substantial. In 1992, cough mixtures over the counter were already retailing at about Z\$20 per bottle. Assuming that they would also need entertainment and other "non-essentials" like toys for the child, their budgets could never cope because toys were imported, scarce and expensive prior to the liberalization of the economy in 1992.

As for furniture, television sets, radios, cookers and beds, those items cost more than could be accommodated in the family budget of most doctors. So, the average junior doctor would have to economise on many things, including living in cheap accommodation in order to be able to buy a bed and other furniture. Marriage payments for doctors are also "market-driven" so the ordinary junior doctor can expect to pay a hefty bridewealth as long as his in-laws have the perception that his future earnings are likely to be substantial in comparison to theirs.

Given the above, it is not difficult to understand that junior doctors cannot realistically expect to live at the standard that their colleagues could attain in government service in 1980. As for the nurses, by 1990, their wages had deteriorated so significantly that they were earning less than teachers and secretaries in the public sector. They could only make ends meet by getting married or leaving the public service altogether. As can be seen from the figures on the numbers of nurses in the public service, there is significant attrition with many nurses going into business, joining banks and private companies, working for non-governmental organisations or emigrating to Botswana and the U.K.

General Discussion and Analysis

The professions after independence

The findings reported in this study raise important issues related to the professions and their trajectory in independent Africa. In Zimbabwe, amongst black people in particular, doctors and, until the 1980s, nurses, have been socialised into expecting a high social status and comfortable lifestyles given the prestige and material rewards that were associated with the medical profession during colonialism as well as immediately after independence. As Cotgrove (1978) has correctly pointed out, jobs have traditionally been an important element in identity formation among people. In the case of Zimbabwe, role strains have become evident in the medical profession in spite of the fact that doctors and nurses are supposed to be bound by their "calling" which assumes that they will serve without regard for money. Nurses are bound by the example and tradition of Florence Nightingale which stresses selfless service. Doctors are also bound by the Hippocratic Oath and it is assumed that these medical professionals work primarily for the common good and only secondarily for money. The ideology of selfless medical service and the relatively high remuneration that Zimbabwean medical professionals have been accustomed to since colonisation clashed when the remuneration to doctors and nurses started slipping in relation to the earnings from other occupations after independence.

In the case of doctors, there are different issues that have coalesced to produce their dissatisfaction with the profession as regulated in Zimbabwe after independence. Doctors have traditionally been the students with high scores in the sciences in secondary school. They study for their degrees for five to six years in comparison to their colleagues in other faculties where honours degrees are awarded after three years of study. Thus, they have been socialised to expect a high status and relatively large earnings as the reward for the scarce expertise which they have acquired after their prolonged period of study in universities. Thus, when doctors graduate at the University of Zimbabwe, it is customary for parents and relatives to ululate and expect benefits in the form of financial support from their doctor children.

However, when junior doctors entered the health system after independence, they were rudely awakened to the reality that their earnings were so low and workload so heavy that they were unable to reconcile their aspirations towards lives of comfort with the fact of their low pay which, like the pay of other workers, was also being eroded by inflation as well as by other

developments in the labour market. New occupations and jobs that have opened up for black people since independence have also shifted the status system away from the traditional professions such as medicine and teaching. In fact, in the course of the research for this study, there was occasion for the principal researcher to discuss the salaries of junior doctors with one of the research assistants. She was aghast when she found out how much (or rather, how little) junior doctors earned in comparison to graduates from the business faculty. She expressed shock at the fact that doctors studied for five years and did another year of internship only to earn such low salaries. She was amazed that the students who normally enter the university with the highest passes and are regarded as the "cream" of the undergraduate academic population are then "de-creamed" (for lack of a better term) on the job market in this manner. These sentiments must be understood against the historical fact that medicine has always been viewed as the pinnacle of achievement for most students. Black people were not exposed to the full range of occupations, the conditions of work associated with them and their structures of pay before independence. This is as true for the parents of university students as it is for their teachers and other people who normally counsel potential undergraduates on career choices. Most black Zimbabweans have, until recently at least, been exposed to certain historically-influenced preferences on careers and these preferences are mostly based on the knowledge, often in the form of general assumptions, of the students and their parents about the relative statuses and remuneration of different types of jobs and professions in Zimbabwe.

Thus, in a profession where the clients were primarily white and/or middle class people, the medical profession in colonial Zimbabwe was allowed to be self-regulating. This regulatory function was undertaken by the Health Professions' Council which was dominated by doctors. The medical professionals, particularly doctors, therefore, had a large degree of autonomy and they enjoyed a lot of influence in the society since there were and still are some functions that can only be legitimately performed by doctors, e.g. the signing of death certificates, certifying people sick or healthy for occupational and insurance purposes, and certifying other doctors. Thus, in Zimbabwe, during the colonial period, doctors largely determined their work and market situations through restricting training and pegging their worth on the market.

The government of independent Zimbabwe transformed the conditions under which doctors and nurses labour. By restricting the ability of newly qualified doctors to specialise and enter into private practise, and by stigmatizing private practise without government service, the government was able, effectively, to regulate the market for medical services and the supply of medical practitioners in both the government and private sector. These interventions were coupled with the introduction of a national health service

with a primary health care emphasis, thus weakening the market position of doctors as a whole in Zimbabwe. However, these interventions had differential effects on doctors and nurses depending on their race, gender and seniority. It is also important to note that the medical professionals did not accept the government's initiatives without a struggle. The fact that these changes were sustained into the 1990s under adjustment meant that junior doctors were able to use the very deregulation of the economy that was part and parcel of cutbacks in the public sector to evade "capture" by the government and explore different options elsewhere as well as in the private sector in Zimbabwe.

Loss of relative status as an issue in the public medical sector

In Zimbabwe, nurses and doctors in government service found themselves losing status, prestige and incomes as medical school intakes rose after independence. However, for them the downward mobility that they have experienced has been made all the more traumatic because they have been superseded by people in other occupations which have not traditionally carried high prestige and incomes, at least amongst black people in Zimbabwe. Zimbabwe inherited the British class attitudes of showing disdain for workers who are semi-skilled, for merchants and business people and artisans. In the field of medicine, the junior doctors and nurses were to find that the declining status of their profession has not been helpful to them in particular. Nurses and doctors have traditionally used their professional associations to plead their case to the government and pursue their interests. For a very long time, they eschewed the kind of unionism that is favoured by disempowered and non-professional groups which have a low standing in the hierarchy of occupations.

In 1988, the first ever strike by doctors in the history of Zimbabwe was greeted with consternation and disbelief by wide sections of the population. People were aghast that junior doctors in a respected and high status profession could resort to actions that were more commonly associated in the public imagination with manual and uneducated workers such as bus drivers, miners and factory workers. The media covered the strike extensively and, interestingly, the senior doctors supported the striking junior doctors. According to Mutizwa-Mangiza (1996), private practitioners sent a delegation to the President asking him to secure the release of junior doctors who had been arrested during the strike. What inferences and conclusion can we draw from these events?

In the first instance, the strike by junior doctors revealed the differences in interest between them and the senior doctors in the civil service. These differences will be discussed more extensively later in this report. However, the

senior doctors lent their support to the junior doctors because they too felt that government was contributing to the erosion of the status of doctors by paying them low wages and not giving them call duty, housing and transport allowances. The bonding over of doctors by the government was also resented because it limited the mobility of the junior doctors within the market. The private medical practitioners who pleaded for the release of the junior doctors who had been detained were also concerned by the humiliation of their fellow professionals, albeit junior ones, who were arrested and treated as common criminals. This slighted the whole profession and was seen as capable of opening the doors to further similar humiliation of professionals if not checked.

The formation of the Hospital Doctors' Association

In Zimbabwe, the associations and groupings of medical professionals were not initially overtly interested in political activism because of the status of their members and the relatively high incomes which they earned both during colonial rule and shortly after independence. The arrest of doctors for protesting falling real incomes and conditions began to push them into actions similar to those of employee organisations, such as the traditional trade unions, that have had a history of adversarial relations with employers in Zimbabwe. The associations of professionals were reluctant to take on a militant role because their members have traditionally been shielded from the need to undertake overt struggles against the government. However, deteriorating conditions of service and incomes in the public sector began to change this situation as the junior doctors who suffered the most resorted to strike action in order to press their case for reform.

Historically, the Zimbabwe Medical Association served as an umbrella organisation for all medical professionals regardless of their seniority. However, as the erosion of the salaries of most doctors, particularly the junior doctors, intensified, there developed a need for greater organisational dynamism to check the deteriorating conditions of work in the public health sector. Convinced that the Zimbabwe Medical Association was not in a position to argue their case, junior doctors in the public health sector decided to form their own organisation, namely, the Hospital Doctors' Association, to champion their cause. This association and its members have been at the forefront of the doctors' strikes that have taken place in Zimbabwe since 1988.

The decision by the junior doctors to form the Hospital Doctors' Association and use it as their campaigning vehicle is not surprising given that they are the ones who need specialist training and, therefore, have an interest in ensuring that the public health sector functions at a level that facilitates the completion of their internships and training. Also, the cutbacks in the funding

of the health sector during the structural adjustment years have affected junior doctors' career plans significantly. This explains why they have found it necessary to organise separately, especially as private sector doctors and senior specialists who are also represented in the Zimbabwe Medical Association are less likely to press for improvements to the public institutions since they do not depend primarily on government hospitals for their incomes. Senior and private sector doctors can see patients in their private rooms and book them into private clinics and hospitals. With the deregulation of the economy, there has been a boom in private medical investment in the form of clinics, laboratories, theatres and surgeries so that paying patients need never go to a public institution. Government hospitals are increasingly patronised only by the poor who are not in a position to advocate for a better funded public health system, having been disempowered and made dependent on the same government that has cut back spending on public health institutions. The hospital doctors have, therefore, of necessity, had to organise and operate like a union, calling strikes in order to achieve their goal of negotiating improvements in the public health sector with the government. But the struggle is an uphill one since the junior doctors themselves mostly move on as they complete their internships, leaving for further training or the private sector or getting promoted to senior positions. Thus, a new crop of junior doctors emerges every two to three years to face the same conditions as their predecessors, if not worse.

The junior status of the members of the Hospital Doctors' Association means that they have few senior allies in a hierarchical and status-conscious profession and their organising activities are hampered by their heavy workload as interns and junior house officers. They frequently have minimal organising skills given their heavy study loads in medical school and they are always afraid of political harassment, detention or deregistration as happened to two doctor activists in the 1996 strike of health workers. Finally, these doctors usually have little discretionary income and cannot contribute large amounts of money from their pockets to finance the activities of their association.

Stratification in the medical profession within the civil service

The doctors in the civil service have different interests depending on their post-graduation experience and skills. The junior doctors occupy the bottom rungs of the medical hierarchy. They are bonded to government and cannot specialise immediately after graduating. They have to serve in government hospitals and do the drudge work. They depend on the senior doctors, who are the consultants, for the good reports and evaluations that are required to facilitate their promotion in the civil service and acceptance into post-

graduate training. Officially, junior doctors cannot increase their incomes by selling their skills elsewhere since they are not given their practising certificates immediately after completing their house attachments. However, as some of the senior doctors contended, junior doctors "moonlight" in the surgeries of some of the middle level or junior practitioners just starting in private practise. The senior doctors felt that some of the junior doctors "... are just so greedy and uninterested in practising proper medicine and learning their profession that they are just keen to knock off even when their work is not finished. They just want to make a quick buck" (interview conducted by principal researcher in Harare, February, 1996). Three of the senior doctors interviewed trained in the U.K. and they argue that they did a lot more work during their house training than the junior doctors are doing in Zimbabwe. They are of the view that junior doctors should not be allowed to go into private practise before they have gained enough experience.

Mutizwa-Mangiza also found that, in general, junior doctors do have economic autonomy by default because there is virtually no supervision of their work by the Health Professions' Council. The result of this is that many of them are able to practise even if, officially, they are not allowed to do so. The senior doctors also felt that some of the junior doctors actually earn more than they admit to precisely because they can "moonlight". It is for this reason that many senior doctors take the view that the industrial actions of the junior doctors have brought the medical profession into disrepute.

In contrast to the junior doctors, senior doctors occupy the upper rungs of the medical profession. In addition to their posts in the public health sector, they can also accept teaching positions in the university and operate as private practitioners. They have a lot of autonomy in determining when and how they will allocate their time between government and private practise. They can fall back on junior doctors to attend to most of the drudge work in the hospitals. Thus, while the senior doctors may sympathise with junior doctors, they are not as economically and professionally vulnerable as their junior counterparts and, in some cases, the senior doctors depend on the junior doctors to carry a heavy workload which enables the senior doctors to pursue remunerative work outside government. In fact, one senior doctor conceded that junior doctors are sometimes exploited by their senior colleagues whose work they perform in government hospitals. This viewpoint was affirmed by the Auditor General's report on the Ministry of Health's expenditure in 1994 in the wake of another strike by junior doctors.

Cotgrove (1978) has contended that the term profession is "...an honorific label which is sought by occupations as part of a strategy of maximising autonomy in their work situations and legitimising claims to differential rewards. Successful professionalisation protects members of an occupation from external control". In the case of nurses and doctors in Zimbabwe, em-

ployment in the civil service obviously erodes some of their control over the workplace, the pace of work, and the conditions of labour. Their claims to differential and superior rewards have become more and more difficult to sustain, especially as they compete for rewards with other workers who are similarly affected by the lack of funds of the government.

The opening up of the medical profession and the significant expansion of health care provision by the government have eroded the position of government doctors and nurses. Since the government was forced by its fiscal crisis into an adjustment programme, all categories of workers have had to deal with the loss of real income. In the face of the austerity policies of the government, claims to professionalism do not carry much weight in the struggle for income by doctors and nurses. As a civil service doctor remarked, "Every year we forward our claims to the Public Service Commission with figures and data on the loss of staff and so forth but we are told that we cannot get more money for our staff since the engineers would also use the same arguments to support their pleas for more pay". Thus, the struggle for wages in the government sector has become less genteel and more "unionised".

There is no bargaining machinery of the union type in the government sector. Thus, claims for higher wages have had to be channelled through ministries which then try to argue the case for a particular group of workers. This often involves ministers in various manoeuvres aimed at influencing the treasury and the Public Service Commission. But the limits of this strategy were reached in the late 1980s when increasing stratification in the medical profession began to force different strata of health sector employees to adopt different exit options from the government service. For those who could not exit, the struggle for better wages led to "unionisation" even in the absence of unions in the civil service. Thus, the junior doctors have not been able to resist the drift towards "unionism" while the senior doctors do not have the same incentives to take the "union" option since there are other routes available to them for the realisation of their financial and professional interests. The different options chosen by different strata of workers will now be addressed.

The rationale behind different exit options by doctors

The expanded involvement of the government in the provision of health services after independence threatened the market for those private health practitioners who were already in the private sector. Given that a large proportion of private patients at the time were white, many black doctors were obviously not in a position to run lucrative private practises since most white patients would not have chosen a black practitioner. Thus, the white doctors controlled the private market for health services through the simple

fact that the bulk of the private, fee-paying clientele was white. The black practitioners who were in private practise relied on servicing huge volumes of low fee patients in the high density suburbs to make a living. They, therefore, could not, shortly after independence, sell specialist skills to poor black patients unless they also operated in government hospitals for blacks and low income white patients.

Many black doctors specialised after independence only after doing their stint in government practise. They, therefore, entered the private market long after their white counterparts who had established themselves during colonial rule. The black doctors who were general family practitioners and specialists were the ones who were able to cash in on the boom created in the market by the new middle class of black civil servants, private sector middle managers and skilled workers. These workers were able to get medical aid through partial contributions by their employers, namely, the government and the private sector. This boom lasted until the mid-1980s when the country's balance of payments problems began to be felt and employment began to decline. With the onset of the economic crisis, there was a new problem of unemployment and growing dependence so that the market comprising black patients grew very slowly. The employment that was being created in small enterprises was too low paying to enable the workers to afford frequent private medical services. Therefore, there was intensified competition for private patients by black doctors who were newly qualified specialists and those who had completed government service and were desirous of venturing into private practise.

Long standing and recently arrived doctors in private practise were interviewed for this study. For those doctors intent on going into private practise, the least expensive option was to set up as a general practitioner. Amongst the doctors who were interviewed, there was some agreement that in the large towns such as Harare and Chitungwiza, there was still a sizeable market for general practitioners. In order to set up practise, all a general practitioner needs is a couple of rooms, a receptionist, a cleaner, basic equipment such as a stethoscope, couch, linen, scales, a telephone, a desk, etc. All these could cost up to Z\$20,000 if one were setting up a reasonably stocked practise. However, some general practitioners in the low income practises actually make do with less and they run shoestring practises without telephones, nurses or nurse aides and with very basic equipment. Such doctors make their money by running assembly line type of practises where they see over 100 patients per day. A general consultation costs Z\$80, so the practitioner who can service patients on medical aid can bank on realising at least Z\$8,000 (US \$800) per day before tax deductions.

One private practitioner who was interviewed for this study said the cost of starting up was around Z\$25,000 in 1994 when he went into part time

practise at a low income shopping centre in a large city. This practitioner graduated in 1991 and was "... patient enough to do ... three years in hell" (i.e., government practise). This doctor does all consultations in the afternoons and weekends since he is still in government practise and, therefore, works in a public hospital in the mornings. His start-up capital was obtained from a bank which offered Z\$100,000 when requested for the sum of Z\$50,000. The doctor contracted an accountant to draw up a proposal to the bank and did not have problems securing the loan since banks in Zimbabwe traditionally favour professional and educated people who are considered relatively low risk clients. The interest rates at the time ran at 37%, so the doctor only accepted Z\$50,000 and was able to realise enough from the practise to repay the loan in six months.

This particular doctor services 80 or so clients per day and 80% of the clientele is on medical aid but the 20% who are not are not necessarily turned away when they cannot pay at the time when they are sick. The doctor offers a 30 days' payment facility for clients in distress and is of the view that very few patients default or disappear without repaying their debts. The argument of this doctor is that if a practitioner does a good job, he or she is assured of a large clientele because there is a lot of competition in private medicine and this competition is forcing the standard of medicine to improve even in the low income areas where it is assumed that clients are too poor and disempowered to recognise bad practise.

From the interviews carried out with doctors in Harare and Chitungwiza, it became clear to the researcher that there is an unmet demand for medical services in the high density suburbs since even poor patients would rather go to private practitioners than to government hospitals now. According to another doctor:

I have treated sick people who needed tests, drugs and specialised care and I have tried to have them admitted into hospital. They flatly tell me that they will not go near a government hospital. You are stuck with them in your practise even when you wish they would seek specialised care. They ask you to do the best you can.

The conditions in the government hospitals have already been described from the inside by patients, doctors and nurses who were interviewed for this study. It is evident that there are serious problems in the government sector that accelerate the movement out of government service by doctors. During the course of this study, it was observed that some doctors left before they had completed their internship and compulsory time in government service because they could not tolerate the poor and deteriorating working conditions in the public hospitals. Most of them intended to specialise and either come back to Zimbabwe or stay abroad and amass enough money to buy cars, houses and pay for their children's education within or outside Zimbabwe.

In the course of this study, it was found that the incomes that can be realised from private practise ranged from Z\$39,000 (US\$3,900) to Z\$200,000 (US\$20,000) per month depending on how many clients a doctor was willing and able to attract and service per day. This also depended on the class of practise the doctors were willing to run, that is, whether to aim for high volumes of low income clients paying between Z\$40 to \$50 per consultation or to have a limited number of high income clients paying the standard \$80 per consultation or a mixture of both in different proportions. This sum should be seen in comparison to the income of a government doctor who earns about Z\$10,000 (US\$1,000) per month if he/she is at Medical Officer level and does not undertake private practise on a part-time basis. During the course of this study, it was speculatively suggested that only one officer in government service at the provincial level was known to be exclusively in public service. From the above information, it is self-evident why the government health service is experiencing the problems that it is faced with.

Since the selection of a doctor to patronise is done by the consumer, the doctors should, ordinarily, not be in a position to control patient choice except by building his/her reputation for quality service. But while it is the case that many patients choose doctors on the basis of their reputations for competence and expertise in their fields, it is also clear that in the poorer sections of the towns and cities, patients may select a doctor because of his/her proximity to their neighbourhood or the lower fees charged. Thus, there is, in fact, a limit to how many practises can be accommodated in the poorer neighbourhoods in many towns and cities. These neighbourhoods have also been traditionally serviced by the older black doctors since before independence so it is not very easy for a new or unknown doctor to hang up his/her plaque and start a practise in an established neighbourhood. Therefore, the options left for the new practitioners are to open up new practises in new high density suburbs where there are frequently inadequate services such as electricity, water and sanitation. Thus, new doctors have to move in with the bulldozers, as it were, in order to secure a niche in the larger urban low income neighbourhoods.

In this type of economic and social climate, many newly-qualified doctors cannot survive economically outside government service. They have to aggressively search out unserved neighbourhoods, specialise or go into other types of enterprise. The university teaching appointments and government consultancies are secured by senior and experienced doctors. Thus, for a doctor who has not specialised, they have to have been established in the mid-1980s or to have secured good locations in large low density and high traffic large city neighbourhoods to survive. This limits the number of doctors who can enter the private sector and make a good enough living to protect their traditional status, income and prestige. These economic difficulties and socio-political realities have forced black junior doctors to leave for greener pastures

to specialise or earn incomes that can allow them to live like the professionals and high income people they have been socialised to expect.

The senior black doctors are able to survive because they have established reputations as specialists and general practitioners and can maintain their statuses by accepting teaching appointments and government consultancies that reaffirm their economic value and professional status. These doctors are the ones who mentor younger doctors and give them opportunities for economic and professional advancement as locums. These are the doctors who become the role models for the junior doctors.

Stratification amongst senior and junior doctors

There are, as Mutizwa-Mangiza (1996) indicates, cleavages which have a historical basis amongst medical professionals. These are between nurses (state registered and state certified), junior and senior doctors, and specialists and general practitioners, amongst others. These stratifications are reflected through differentiated incomes, prestige, status and power in both the private and public medical sectors. The reason why it is the junior doctors who migrate rather than the senior ones is that, according to the junior doctors who were interviewed, it is the junior doctors who feel the pinch in government service. The junior doctors felt that they were unable to secure the support of the senior doctors in their struggle for improved conditions of work. According to the junior doctors, the senior doctors are mostly in private practise and have nothing to lose if the government health sector collapses. According to one doctor:

...When there is confusion in the government hospitals, the senior doctors benefit from the patients who turn to private medicine. Some of the senior doctors have connections with the politicians and are not willing to speak up in defence of the profession as a whole. In the end, junior doctors make noise and then leave (to specialise or to make their fortunes out of Zimbabwe) so it is the senior black doctors who stay around longer in the government system which they will not do anything to improve. The white doctors pull out and go into the private sector to look after white patients.

On the other hand, the senior doctors who were interviewed felt that the structures of reward in the government health service were not logical. One specialist pointed out that the very junior doctors at house level are given transport and housing allowances which the more senior medical officers do not enjoy. He was of the opinion that the junior doctors are too "rough" and "outspoken" and this was why they were able to secure these allowances for themselves. The senior doctor felt that nurses were the most grossly exploited group in the medical profession and that the government could not real-

istically expect them to stay and work under the present conditions for the pay they are getting.

Senior doctors as a group also tend to object to the "unorganised" nature of the industrial actions taken by junior doctors. They feel that the junior doctors just "down tools" as a knee-jerk reaction to frustration and that this approach is not very productive. There is an obvious division on strategy influenced by the amount of time that junior and senior doctors are willing to wait in order to have their problems looked into. These differences have a lot to do with the differing economic and social circumstances of the junior and senior doctors.

Most senior doctors who are specialists and are practising solely or predominantly in the private sector earn in excess of Z\$1.5 million per annum after tax. As has been indicated by the general practitioner cited above who confided that they earned at least Z\$1 million after tax, specialists charge more per consultation and depending on the degree of shortage of skills in their specialisation, they can realise over Z\$3 million per annum after tax. It was not possible to get any of them to indicate their exact earnings but according to some general and specialist practitioners, in the ranking of earnings amongst specialists, the radiologists earn the most, followed, in order, by ophthalmologists, urologists and general practitioners. These figures are certainly credible given that surgical specialists charge at least Z\$152.45 for an initial consultation and Z\$78.25 for a subsequent one and even more for surgical procedures. The medical specialists earn Z\$296.20 for an initial consultation and Z\$108.55 for subsequent ones.

Given that private practitioners can claim a large proportion of their telephone, transport, furniture and related spending as legitimate expenditure on tools of trade, their lifestyles are quite comfortable. It is, therefore, not surprising that their choice of approach to workplace problems is linked to their ability to tolerate prolonged bargaining and negotiation with government, an approach which, from the point of view of junior doctors, appears as collaboration with the government. Since senior doctors are not exactly on the breadline, they can also afford to invest in etiquette and procedure in their dealings with government since their lifestyles are vulnerable to government regulation as happened, to a limited extent, in the early 1980s. Senior doctors have invested in training, expensive equipment and their practises over time so they have a lot to lose if government decides to be punitive through all manner of regulations. In contrast, junior doctors feel they have nothing to protect in struggling for better wages and working conditions in the same manner that unskilled workers have done since independence.

Nurses and their organisation

Nurses have to deal with the fact that they are at the bottom of the medical professional hierarchy which privileges doctors, who are predominantly male, over nurses, who are predominantly female. For this reason, nurses have, over the years, found themselves waging struggles for improvement in their conditions of work independent of the doctors. This has culminated in the decision by nurses to form an association of their own and to challenge their limited say on the Health Professions' Council in spite of the fact that they constitute the majority of the registered and dues-paying members of the health professions in Zimbabwe.

The current problems being experienced in the health sector have a lot to do with the demoralisation of the nurses who, as one nurse said, "... are treated as the handmaidens of the doctors". Nurses feel that they are treated shoddily by both government and most doctors who tend to bully them and act out status differences in the workplace. How this issue will be resolved is still unclear in the face of the government's professed inability to pay decent salaries to nurses. As it is, some nurses are voting with their feet and leaving the profession altogether or alternatively, joining the non-governmental and private sectors. Those who remain say they are disgruntled and demoralised. Judging by the public's constant complaints in the press, there is certainly a lot that is wrong with nursing services in the hospitals.

The nurses started organising in the late 1980s and now have an association, the Zimbabwe Nurses' Association, which champions their cause. The association is currently trying to get the government to promulgate a separate piece of legislation, a Nurses' Act, to govern its members as professionals. The Zimbabwe Nurses' Association has been successful in bringing the cause of the nurses to the public arena, bargaining for improved conditions for nurses, and establishing a presence that is powerful in the Health Professions' Council. The Health Professions' Council has historically been doctor-dominated despite the fact that the majority of the dues-paying members of the health profession have been State Registered and State Certified Nurses. This is partly due to the fact that in the British health service after which the colonial health service was modelled, nurses are subordinate to doctors and their tasks essentially low technology based as opposed to the relatively high technology role of the doctors. The gender segmentation which has been observed in the Zimbabwean health service has tended to translate into gender discrimination, resulting in women's work in the health service being underpaid and undervalued in comparison to that of the men. As Sanders (1985) contends, the work of other health professionals is almost always

defined in relation to that of doctors to whom these other health professionals are subordinated in the medical hierarchy.

Under conditions of economic stricture, nurses are increasingly unable to "care" for and nurture patients, especially with the devaluation of medicine and its loss of prestige as a profession at all but the private and specialist levels. In the absence of status and good pay, the caring ethic is rapidly being eroded with women abandoning the profession altogether or going into private nursing or migrating to better paying countries. Thus, caring has been shown to occur under specific conditions, namely, when people feel their profession has status, gives them satisfaction, has public recognition and respect, and is well remunerated. As nurses' salaries and conditions started to deteriorate in the 1980s, their career strategies also changed with more women going into teaching, commerce and industry and others migrating in the same way that peasant and working class men had done in colonial Zimbabwe.

Dissatisfaction amongst professionals in the health sector

Having analysed the conditions under which health professionals labour in the health sector, the issue of dissatisfaction with their work needs to be addressed. While it is difficult to pinpoint what particular issues and problems may produce dissatisfaction for each health professional, it is still possible to identify a number of factors that contributed. The first and most obvious issue is the lack of money to maintain the present levels of staffing, pay and conditions of service for professionals in the health sector. Since the inception of the structural adjustment programme, the government has, among other things, made a conscious choice to cut back spending on the health sector. However, what that decision did was to introduce new problems on top of those that already existed before the SAP. The SAP was ostensibly undertaken to deal with the declining revenue base of the state, the deterioration in the productive capacity of the economy and the slowdown in job creation. At the workplace level, what the SAP did was to make work even more demanding and the conditions of work less pleasant for doctors and nurses while the service provided to consumers became less satisfactory.

While strikes in the health sector have been the most dramatic manifestation of the dissatisfaction amongst health professionals with their work and the conditions under which it is performed, less dramatic forms of dissatisfaction have been manifested through the rapidity of labour turnover. Many nurses and doctors have left government service for the private sector in Zimbabwe while others have left Zimbabwe altogether especially if they wanted to stay in the profession and increase their income and/or qualifications. Thus, health personnel, have had to choose how to deal with their dissatisfaction and a significant proportion have chosen to leave Zimbabwe as

well as government service. This has left those who, for different reasons, cannot leave Zimbabwe or government service to deal with the worst aspects of the decay of the health services in Zimbabwe. Particularly badly affected among those who stayed behind are the junior doctors and nurses.

Given the government's hostility and aggressive responses to all strikes, employee groups have had to couch their dissatisfaction in a language that is non-political and is, therefore, acceptable to the state in the first instance and then to the wider society. Thus, nurses and doctors ask for more pay, better risk allowances, retention allowances, night allowances, transport allowances etc. However, non-health sector employee organizations have difficulty taking the government head on about the state of the health service. They cannot articulate the grievances of the majority of the population about the state of the health services because, traditionally, the health professionals have been perceived to be at the top of the professional pecking order and, therefore, distanced from the hurly burly of the political arena. Thus, their occupational history in Zimbabwe has cut them off from the more direct channels for negotiating their grievances.

The associations of professionals do not have much direct influence over the state because in the civil service, there is no machinery for collective bargaining. During the 1990s, the government pressured employees not to demand large pay increases and as a mark of its seriousness, it took the lead in curtailing bonuses and other perks to its employees at a time of high domestic inflation. Thus, the lack of alternatives for supplementing incomes through informal work and, in the case of junior doctors, the withholding of practising certificates until government service had been performed, diminished the possibilities for private work for health sector workers. It was inevitable that workers' energies would be directed at improving formal work conditions and pay rather than exploring alternatives for income supplementation outside the workplace. Thus, instead of taking individual action and pursuing individual solutions to diminishing incomes and poor work conditions, health workers started organising in their workplaces to deal with their dissatisfaction.

This is not to say that there is no personal dimension to dissatisfaction at work. As has been shown in the example of the two migrant doctors profiled in this report, the same conditions of work can generate different expressions of dissatisfaction among different people depending on their tolerance, ability or willingness to defer gratification, and plans for their future. As can be seen from these profiles, the expectation has been that junior doctors have to put in time as interns while they wait for their chance to specialise, become consultants and private practitioners. However, that career trajectory has been threatened by the economic reform programme and the rationalization of the government's expenditure. There is no guarantee that the junior doctor who

waits will be able to get trained in a badly equipped hospital with busy and, in some areas, virtually absent consultants. Waiting also delays the junior doctor's entry into private practise where money can be made. In the meantime, colleagues who eschew specialisation can move in as general practitioners and dominate another chunk of the market, particularly that of patients on medical aid. This particular niche of the market is endangered by retrenchments and redundancies amongst semi-skilled and clerical workers in government.

It is not surprising that some junior doctors like Doctor X, rather than struggle to get better government investment in the health sector, opt to leave, specialise and go into private practise on a part-time basis thus "having it all", albeit in a different country and environment. Others like Doctor Y, also eschew struggle in the health sector, leave, specialise and probably return as private doctors in a high-paying area of specialisation. Yet others, like the doctors who have remained in Zimbabwe, may "put in their time in hell", go into private practise part time while waiting to specialise. Whether they will actually specialise in Zimbabwe is a moot point but they will have earned high incomes and met some of their expectations as professionals.

As has been indicated in various interviews, especially those with the nurses, many of the assumptions about professionalism have been eroded by the health professionals' experience in the crumbling health service. Meritocracy, realisation of potential, guaranteed rewards and autonomy are some of the values that have been lost. The gap between the expectations of newly qualified health professionals and the reality that they find on the ground is just too wide. The role of politics in shaping the professions cannot be ignored any more and this realisation has generated different reactions among the health professionals. Those who feel that they cannot play the political game in order to advance themselves opt out of the public sector and take up practise in the private sector where government influence is not as obvious and as intrusive. Those who can leave do so and can later decide when to return and on what terms. Those who are "trapped" in the service try to complete their time without falling foul of the system. Some do not succeed as the two deregistered junior doctors who were in the strike of 1996 will testify.

Thus, the nurses and doctors who left were the ones whose dissatisfaction took on a dramatic manifestation. Their dissatisfaction may well have diminished as their status in the system improves through specialisation and they return as better qualified and individually empowered private practitioners. While the macro situation in the economy and the health sector remains the same or deteriorates, the turnover of health personnel is likely to continue as dissatisfied practitioners leave, strike, drag their heels at work and some eventually return to the private sector. In the long term, this might be a mani-

festation of the increasing privatisation of the health sector with only the most rudimentary public health institutions remaining to service the most destitute.

Private and personal dissatisfaction among health practitioners is not likely to turn into collective action with nurses, junior and senior doctors and consumers of health services getting organised to pressure government to reform the health sector for the benefit of the patients in the first instance. Instead, individual doctors and nurses will change sectors, countries and professions as long as their skills are in high demand. Nurses have less room for manoeuvre since there is a limit to how fast the private health sector can expand to accommodate experienced nurses. Their numbers are larger than those of the doctors. Doctors, on the other hand, can exercise a wider variety of options including total private practise, government and partial private practise, locums and government practise and migration to neighbouring countries where there are opportunities to specialise and enter private practise eventually.

In the meantime, the younger junior doctors will have growing incentives to demand more pay and more allowances and perhaps, to start posing more direct political questions about state priorities in the planning of public expenditure. In the medium term, medicine might not remain such an attractive career for young people coming out of high school especially if the private sector health market becomes more competitive. Judging from the experiences of other adjusting African countries, it is not conceivable that the government will improve remuneration, working conditions and technology in the health sector to a dramatic extent. Therefore, it is not unreasonable to expect that the form in which the public health sector can develop will not be along the western curative high technology model. Ironically, the state might have to readopt aspects of the Chinese model which it has supposedly jettisoned, in favour of the market model, not because of a strongly-held conviction about the appropriateness of the Chinese model in a developing country but because of its cost effectiveness.

User fees as a non-solution to deteriorating public health care provision

Part of the state's adjustment programme has involved the levying of user fees on patients. This is partly a result of the fact that spending on health has plummeted, reaching an all time low in 1992/93 when only 2.5% of the national budget was spent on health. In the 1991/1992 financial year, the government started enforcing user charges as part of its cost-recovery effort. Under this programme, people earning less than Z\$150 per annum were exempt from paying the levy. By mid-1992, the exemption level was increased to Z\$400 in recognition of inflation, joblessness and the real cost of drugs, consultations etc. In order to increase revenue, the costs were raised again in

1994 to cover central, district and rural clinics so that those who could pay did and those who could not, had to show documentary evidence from employers, councillors and government social welfare agencies that they could not. The government announced in 1994 that user fees would be introduced all round so as to increase the budget contribution from health from 3% to 33%. Table 20 summarises the prevailing user charges in different health facilities in Zimbabwe.

Table 20: Health sector user charges

Year	Hospital	Service type	Adult fee/day	Children's fee/day
1994	Parienyatwa Central Hosp	Outpatient	Z\$ 42	Z\$ 21
		General ward	Z\$200	Z\$100
		Private ward	Z\$450-500	Z\$225-275
		Intensive care	Z\$300	Z\$150
		Maternity ward	Z\$100	N/A
1996	Parienyatwa Central Hosp	Outpatient	Z\$ 64	Z\$ 32
		General ward	Z\$375	Z\$170
		Private ward	Z\$ 625-825	Z\$340-415
		Intensive care	Z\$450	Z\$225
		Maternity ward	N/A	N/A
1996	Harare	Outpatient	Z\$ 52	Z\$ 26
		General ward	Z\$120	Z\$ 60
		Private ward	Z\$250	Z\$125
		Intensive care	N/A	N/A
		Maternity	N/A	N/A

Source: Author's field survey.

These fees applied to all government hospitals in the same category countrywide. Private hospital fees are charged at over Z\$1,000 for admission per day and are only accessible to people on medical aid or with very high incomes.

The immediate impact of the introduction of user fees was a decline in attendance at health facilities with the effect that the incomes that were expected to flow from such attendance could not be realised. Tuberculosis, mental illness, and leprosy were not subject to fees and by 1993, diarrhoea treatment was also made free. Despite these measures, transport costs, drug shortages, poor service delivery and the parlous state of clinics and hospitals deterred patients from attending government facilities. According to the private practitioners in Chitungwiza, a low income town, even the poorest households now try to access the private practitioners on credit or under some other arrangement since there is not much point in attending a government facility where there are no drugs or doctors and registered nurses to attend to patients.

The decline in attendance at health facilities and the channelling of patients to private practitioners, traditional healers and other services has frustrated income generation through user fees by government. It is, therefore, quite difficult to try and provide financial incentives to doctors and nurses by levying patients who, in most cases, cannot afford to pay for health services. According to the hospital superintendents and administrators who were interviewed, even if a hospital collected fees assiduously, these fees would not accrue to the hospital in question but would go to the government's central account. Thus, there is no incentive to collect the fees. Even the fees of patients who are supposed to be covered by the Social Funds for the poor, are not forthcoming from the government so that, in effect, most hospitals are owed money by the government. It is a vicious circle. It is not possible to deal with incentives for personnel outside the arena of general fiscal policy in the civil service.

The alternative

The alternative to a health care system that is built on high salaries for doctors and specialists would be to take the existing community-based primary health care programmes that have been introduced in the country to their logical conclusion by relying less on hospital-based doctors and nurses and more on health teams based in the communities where the patients reside. Sanders (1985) has described aspects of this community-based system as it functions in China, Cuba and Bangladesh. Using the colonial Zimbabwean model which was based on the "supernurse" that was unfortunately abolished at independence, it would be possible to provide more specialised medical training to SRNs with work experience so that they could supervise and train a huge cadre of village and district residents to provide environmental, health and preventive education and medical care while dealing with minor surgery and some specialised procedures at that level.

These health workers would be paid competitive salaries and would be encouraged to work under decent conditions but would not stay in medical school for six years and would make an impact from the beginning since they would be working in their communities. The government hospitals would retain some specialists for referral purposes and do away with the problem of centralisation and the differential endowment of institutions with money, drugs and other necessities which, currently, tend to be concentrated in the urban and provincial hospitals. The doctors who desire specialised and expensive training could still pay for themselves to undertake this training.

The state, in turn, would have to refocus its health spending to cover sanitation, vaccination, education and popular mobilisation which would make people more responsible for the services that impact on their health. At

the moment, government has taken decisions about health in ways that have undermined the health of the very people it claims to serve while demoralising health workers who were trained at great expense. This has resulted in the alienation of many health workers such that an estimated 70% of physicians and 60% of the nurses are privately employed in Zimbabwe and neighbouring countries. The rural and urban poor have suffered in this situation since they cannot access the private health system while the public health system is so run down that in some cases, it can be dangerous to patients.

Conclusion

The major question that Zimbabwe faces today is whether it can afford professionals in health who would be paid at the rates which would attract them into and keep them in the public service. This is an important issue because, as this study shows, the average doctor who entered medical school in the first instance because of very high academic grades, undergoes many years of medical training which is focused more on the physical and technological aspects of medicine and less on social medicine. The best remunerated and regarded practitioners are in curative medicine and virtually all doctors aspire to a similar status and comparable earnings. The private and senior practitioners focus on individual cases that fall within their clinical specialisations but their interest in and commitment to teaching even that clinical aspect is waning or competes with their individual career and entrepreneurial ambitions and activities in the private sector.

The sectors and specialisations in which doctors focus are outside the reach of the poor and the majority of the patients in Zimbabwe are poor. Private medicine is too expensive for the majority of Zimbabweans to be able to afford while doctors expect high remuneration for their skills, training and expertise. Many private and government health practitioners spend most of their time treating simple and preventable diseases which do not tax their expensive training. Despite the fact that these points were recognised after independence, very little transformation has taken place in medical training and restructuring, partly because the top managers and administrators in the public health sector are themselves western and/ or university trained doctors with a vested interest in the present health system despite its problems and inefficiencies.

However, this study has shown that the coercion of doctors through the withholding of practising certificates does not work. It either drives junior doctors to migrate or to do their stint in government and leave as soon as possible. Unless government invests in the services and infrastructure, commerce and industry in ways that benefit the majority of rural Zimbabweans, there is little prospect of retaining doctors and nurses in rural areas and in government service in urban areas. As this study has shown, most doctors and nurses would rather take their chances in the private sector or use the government sector for training and experience which they will then deploy for maximum financial gain in the private sector or overseas.

Government needs to raise the standards and quality of public health institutions especially at the village, district and provincial levels so that people do not have to flock into central hospitals for treatment of minor ailments and doctors do not have to spend their time doing unchallenging work with meagre resources. This is especially so with the spread of AIDS which cannot be handled through the existing curative structures. Now is the time to refocus health priorities and redefine health practitioners' roles rather than continuing to dissipate energy on ways of exercising futile control over doctors who cannot be retained at the present remunerative levels and conditions of service. The experiences of other adjusting countries show that they too have been unable to retain their nurses and doctors in the public service unless they pay them salaries that their adjusting economies cannot sustain. In Botswana and South Africa, the average black patient is more likely to be attended by a Zimbabwean, Zambian, Nigerian, Ugandan or Ghanaian doctor than a South African or Tswana one.

While the UNDP and the IOM may try to intervene to repatriate individual professionals to Africa, their chances of success are minuscule because the outmigration of professionals is not diminishing. These bodies do not address the macro issues in African polities and economies and it is these macro conditions that often lead professionals to migrate out of Africa. The health professionals' exodus into private medicine will also not abate. This has been demonstrated by this study as health professionals pursue their personal and career ambitions in ways that do not necessarily accord with the plans of the Ministry of Health. The health professionals do not migrate only because they are pursuing individual careers for themselves; they also assess the political and social environment so that they can determine whether the country's policies augur well for their children's education, health and general welfare. As was evident from the cases profiled in this study, many professionals migrated because they did not place much hope in the school system, the future of university education, the prospects for post-graduate medical training, the political and governance systems and the future of the economy of Zimbabwe. Among these concerns are political issues which they factored into their decisions to migrate, although most of these respondents did not identify themselves as "political" people. In fact, many respondents and those who refused to take part in the study did not want to be engaged by the researcher on the political aspects of their migration decisions. They wanted to do the best for themselves and their families by voting with their feet. They 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. They did not want to sacrifice themselves, their skills and their

children's futures in an uncertain political and social climate. Their decisions cannot, therefore, be dismissed simply as unpatriotic.

The study also showed the gulf between the reality of migrants' decision making contexts and the assumptions of the officials in the Ministry of Health. In the nursing profession, the most valuable, experienced and specialised nurses were the ones who were leaving while the junior ones remained in the system. This is costly and the Ministry of Health needs to take this into cognisance when designing its incentive structures. In the case of junior doctors, it was the ones most desirous of specialisation who left together with those who had wives and children who needed tertiary education and good quality schooling. Amongst the women, two doctors were female and had graduate and professional spouses; the couples migrated because there were good opportunities for post-graduate training and/or highly remunerated work for both of them. The nurses who migrated were skilled and some were married; it is clear that marriage is no longer a barrier to migration by women. These women are ambitious, have highly qualified partners and are, therefore, able to negotiate in their relationships to redefine domestic obligations in ways that allow them to pursue their ambitions as well as get well remunerated jobs that, in turn, empower them in their relationships.

While the health profession remains unreconstructed and doctors and nurses are given very specialised training that equips them for servicing the private sector, it is more than likely that the medical brain drain from Zimbabwe will accelerate well into the next millennium. This has been the experience of other African countries and there is no reason to expect that Zimbabwe and her neighbours will be exceptions to this. While today, the bulk of Zimbabwean doctors and nurses migrate to Botswana and South Africa, as those markets become glutted, the migration will very likely start to be extra-continental.

The diminishing of the private market for medical services will affect most new medical practitioners. This will obviously limit the scope for private practise for those doctors coming into the profession in the future. In many specialisations, there will not be enough room for many new practitioners or alternatively, there will be more competition and the incomes for all but the practitioners in the most severely underserved areas and specialisations will be reduced. In any case, there will still be a need to deal with the issues of staff retention in the government sector in the long term.

This study has shown that professionals make decisions on the basis of a wide range of concerns for themselves and their households and these concerns will need to be addressed by governments. While nurses and doctors undergo training regimes that, together with their professional traditions, tend to make them eschew politics, the increasing politicisation, during the economic crisis and structural adjustment years, of health sector decision

making must be carefully re-considered. Under SAP, unprecedented militancy has been exhibited by professionals, including doctors, nurses, teachers and others. Professionals have found themselves questioning the government on its decisions and actions. The militancy of nurses' and junior doctors' organisations cannot be ignored. The roots of this militancy have been dealt with in this study and the decision to migrate by these professionals is another dimension of the response of health professionals to adverse workplace and wider macro-economic, social and political developments. This study has also indicated that female professionals have begun to deal with the difficulties of the SAP years by adopting migration as a strategy. But the crises of the Zimbabwean health sector are not inevitable and creative alternatives could be explored in order both to improve service delivery and the retention of professional staff.

List of Key Interviewees in Zimbabwe

- 1) Director of Nursing
- 2) Superintendent, Parirenyatwa Hospital, Harare.
- 3) Director of Planning, Ministry of Health.
- 4) President, Hospital Doctors' Association.
- 5) Registrar, Health Professions Council.
- 6) Superintendent, Mpilo Hospital, Bulawayo.
- 7) Superintendent, Bulawayo Central Hospital.
- 8) Regional Director for Health, Matabeleland North Province.
- 9) Officer: Recruitment and Resignations, Ministry of Health
- 10) Minister of Health, Government of Zimbabwe.
- 11) President, Zimbabwe Nurses' Association.
- 12) Former Superintendent, Parirenyatwa Hospital.
- 13) Hospital Administrator, Mpilo Hospital.
- 14) Former Matron, Ministry of Health

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