



Deployment of Human Resources for Health in Zimbabwe: Synthesis Report

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The ReBUILD Research Programme Consortium is an international research partnership funded by the UK Department for International Development.

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

ReBUILD is implemented by a partnership of research organisations from the UK, Cambodia, Uganda, Sierra Leone and Zimbabwe.

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- Institute for Global Health & Development, Queen Margaret University, Edinburgh, UK
- Cambodia Development Resource Institute, Cambodia
- College of Medicine and Allied Health Sciences, Sierra Leone
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Executive summary

Introduction

Deployment determines availability of human resources for health through initial posting of staff and retention of staff in post; and the related human resource management (HRM) functions. Recruitment, bonding, transfer and secondment as a specific form of transfer are key components of deployment. The set of policies that govern each of these functions are managed and implemented by different authorities in different provider organisations and for different cadres. In countries emerging from crisis, implementing deployment policies may be difficult due to weak governance, unclear deployment systems and procedures and lack of capacity by staff who implement the policies. We studied deployment policies in two large providers of health care, government and a large Faith Based Organisation (FBO) in Zimbabwe before, during and after the severe economic crisis from 1997 to 2008.

Aims and objectives

The aim of the study was to identify ways to improve deployment systems to rural areas used by large employers of health personnel post crisis in Zimbabwe. The key objectives were to describe the current deployment policy, systems and practices and how and why they have changed before, during and since the end of the crisis, assess the impact of the changes on the staffing of rural areas, recommend ways to improve the current system of rural deployment and posting of HRH and identify lessons learnt in the development of deployment policy and systems in post crisis situations in Zimbabwe and globally.

Research methods

Both qualitative and quantitative methods were used, with the former providing an in-depth investigation and the latter assessing systems consistency of rural posting of the two healthcare providers in three districts. Documentary review, analysis of staffing data and ethnographic methods (e.g. in-depth interviews, key-informant interviews and life histories) were used.

Results

Working and living conditions were poor during and after the crisis. During the crisis remuneration, availability of medicines and equipment was unreliable. Supervision and support to health workers were poor causing wide-spread dissatisfaction among health workers. In the post crisis period, there were marginal improvements but health workers both in government and FBO still felt that conditions were poor. Other aspects that were of concern to health workers were availability of amenities, transport and telecommunications. Poor

shelter, limited food availability, unreliable access to clean water, availability of electricity and safety were also affecting the living conditions of health workers and affecting their motivation. During the crisis transport was a major concern for health workers both in government and the FBO which affected deployment. Living conditions remained a challenge after the crisis. High workloads derived from the high vacancy rates, increased demand and the recruitment freeze contributed to worsen the working conditions particularly in rural and remote areas. All the above contributed to general dissatisfaction of the workforce. The limited number of approved posts across the health system, the attrition generated during the crisis and the introduction of a recruitment freeze after the crisis led to a severe deterioration of the labour market

The implementation of key HR functions related to deployment (e.g. recruitment, bonding, transfer and secondment) were fragmented during the pre-crisis years. Unification of HR management under the Health Service Board (HSB) from 2005 was not fully implemented due to failure to formalise agreements between government and FBO. FBO continued applying their own processes in parallel with these regulated by the HSB. In this regard the FBO performs the four HR functions on health workers but are obliged to inform the HSB. While FBO and government use the same regulations, the slight variations in implementation emanate from the fact that each entity employs its workforce with the HSB performing the HRM functions as mandated in the Health Services Act of 2004.

Recruitment

Workers preferences for deployment at the recruitment stage, while taken into account before the crisis, were not followed during and after the crisis due to shortage of critical HRH, particularly in rural areas. Induction periods which were consistently offered before 1999 were discontinued during the crisis. Workers who left the workforce during the crisis were allowed to be re-appointed after 2008 through a fast-tracked process which shows the flexibility of the system to mitigate the problems derived from the crisis. FBOs being responsible for most of the professional schools were able to retain the best students after graduation and also to recruit all ordained staff.

Bonding

Bonding policies were not reflected in the two main HRM policies (e.g. PSR 2000 and HSR 2006) but self-regulated by professional associations. Bonding policies were strict before the crisis but relaxed later on to adapt to the problems of attrition generated by the crisis.

Transfer

Transfer policies, while included in the PSR 2000 and later in the HSR 2006, changed during the period covered by this study. During the crisis transfers were requested by workers to cope with the situation but were later restricted after introduction of the recruitment freeze. FBOs used rotatory transfers of ordained staff regularly to cover vacancies in more difficult-to-staff facilities.

Secondment

Applying regulations included in the HSR 2006, managers used secondment to cover critical posts. While periods for secondment were limited to three years in PSR 2000 these were left undetermined in HSR 2006 which led to some participants reporting periods longer than that during and after the crisis.

Conclusion

We compared implementation of posting policies in rural areas in two large employers of HRH government (HSB) and FBO in the pre-crisis, crisis and post crisis period. The results have shown that the crisis severely affected the health workforce triggering considerable attrition and distorting implementation of deployment policies which affected particularly rural and remote areas. The study has revealed that there were no main policy changes triggered by the crisis and that most of the changes occurred at the implementation level. Managers at local level adapted to the precarious situation generated by the crisis adjusting terms and regulations to address the different problems derived from the high attrition and HRH shortages. Government also showed flexibility by relaxing some of the regulations such as the re-appointment procedures after the crisis. Limited access to HRH information (e.g. personnel data) by researchers, particularly in the FBO sector, made difficult to determine the effectiveness of the deployment policies. However, the multimethod approach used in this study allowed to provide explanations from the participant's perspective. The study revealed the complex nature of the FBO/HSB relationship and identified ways to improve deployment systems to rural areas used by large employers of health personnel post crisis in Zimbabwe.

Recommendations

From our analysis of the findings of this study, we present two sets of recommendations – the first relating to Zimbabwe and where it is now; and the second for other countries imminently emerging from crisis.

Lessons for Zimbabwe

This study was carried out between 2013-15. Policy changes may have been introduced since then, but these lessons are based on the findings of this study:

- 1 Clarify the inconsistencies regarding the status of non-ordained health staff in the large FBO facilities and deployment rules governing them. The FBO is the largest provider of health services in rural areas and if the underlying disaffection by non-ordained staff is not dealt with an exodus is inevitable which will affect rural dwellers.
- 2 The HSB probably needs to be able to negotiate harder with the Ministry of Finance to gain further concessions regarding the blanket freezing of post. This will require better HR information and the development of models to demonstrate both the short and longer-term impact of the recruitment freeze on the health workforce. It will also require a coherent strategy – including the use of deployment-related policies – to demonstrate how the health sector will get greater value from the workforce.
- 3 When it is feasible, the provision of three preferences for the initial posting should be reinstated to improve the chances of retaining staff and the utility of bonding policies reviewed.
- 4 District level managers should be provided with a better understanding of deployment strategies (initial posting, bonding, transfer and secondments, and reappointment) and possible unintended consequences resulting from the use of these strategies. They should then be encouraged to implement the deployment-related policies in the most appropriate way to achieve a balance of vacancy reduction and staff retention.

Lessons for other countries emerging from crisis

- 1 The effects of the changes in the wider policy context on deployment during the crisis and post-crisis periods as well as the actual deployment-related policies on staffing in rural areas need to be understood by policy-makers before deciding how to address problems.
- 2 Human resource management information systems, however basic, across all major employers are needed during crisis and post-crisis period to understand the effects of changes in the wider policy context and deployment-related policies and, where possible, to make appropriate adjustments within the prevailing labour market conditions.
- 3 Local managers need technical support and sufficient authority to adapt implementation of deployment-related policy to address staffing problems. This is particularly needed in times of crisis, but if they are also supported at other times their skills in adapting implementation will be greater. The managers should also be made aware of the unintended consequences of changes to the way deployment policies are implemented and the potential negative consequences for other areas of human resource management.

List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
BRTI	Biomedical Research and Training Institute
CADEC	Catholic Development Commission
DDF	District Development Fund
DEHO	District Environmental Health Officer
DHE	District Health Executive
DMO	District Medical Officer
DNO	District Nursing Officer
EHO	Environmental Health Officer
EHP	Environmental Health Professionals
EHT	Environmental Health Technician
EOH	Executive Officer Health
EPI	Expanded Programme of Immunisation
ESAP	Economic Structural Adjustment Programme
FBO	Faith Based Organisations
FCH	Family Child Health
GBV	Gender Based Violence
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HND	Higher National Diploma
HOD	Head of Department
HR	Human Resources
HRH	Human Resources for Health
HSB	Health Service Board
HSR	Health Service Regulations
HTF	Health Transition Fund
HW	Health workers
ICU	Intensive Care Unit
IDI	In-Depth interviews
IMF	International Monetary Fund
KII	Key Informant Interviews
MC	Male Circumcision
MLIC	Middle and Low Income Countries
MLIC	Middle and Low-income Countries
MoESC	Ministry of Education Sport and Culture

MoF	Ministry of Finance
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care
MoHCW	Ministry of Health and Child Welfare
MoHTE	Ministry of Higher and Tertiary Education
MRCZ	Medical Research Council of Zimbabwe
MSU	Midlands State University
NCZ	Nurses Council of Zimbabwe
NGO	Non-Governmental Organisation
NIHFA	National Integrated Health Facility Assessment
NUST	National University of Science and Technology
OI	Opportunistic Infections
OPD	Out Patients Department
PCN	Primary Care Nurses
PEHO	Provincial Environmental Health Officer
PEHT	Provincial Environmental Health Technician
PMD	Provincial Medical Directorate
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PNO	Provincial Nursing Officer
PS	Permanent Secretary
PSC	Public Service Commission
PSR	Public Service Regulations
RBF	Results Based Financing
RCZ	Research Council of Zimbabwe
RDC	Rural District Council
RGN	Registered General Nurse
RHC	Rural Health Centre
SCMN	State Certified Maternity Nurse
SCN	State Certified Nurse
SDGs	Sustainable development Goals
SIC	Sister in Charge
SSB	Salary Service Bureau
TARSC	Training and Research Support Centre
TB	Tuberculosis
UBH	United Bulawayo Hospital

UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UZ	University of Zimbabwe
VHSSP	Vital Health Services Support Programme
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
ZACH	Zimbabwe Association of Church
ZIMRA	Zimbabwe Revenue Authority
ZIMSTAT	Zimbabwe National Statistics Agency

1. Introduction

In the past decade, the initial emphasis in tackling the so-called “human resources for health crisis” (JLI, 2004) has been on scaling up the health workforce (Crisp et al, 2008). However, the maldistribution of health workers and the associated difficulty of filling health worker posts in rural areas has long been recognised as a serious challenge to the equitable provision of healthcare and the achievement of the health-related SDG3 (Campbell et al 2013). Much research has already been devoted to understanding health worker behaviour in relation to taking up and remaining in posts in different locations (Dussault, 2006; Lehman et al 2008; Lemièrè et al 2011). The problem of maldistribution is also exacerbated on the management side by ineffective deployment systems (Vujicic 2009; Schaaf and Friedman 2013).

The term ‘deployment’ is frequently used in relation to distribution of staff, but rarely defined. One of the few definitions found is in the Canadian Public Service Employment Act which states that deployment means “*the transfer of a person from one position to another*” (Government of Canada 2016). We interpret deployment more widely in this study as including functions that are elements of the recruitment process such as the initial selection of students for pre-service training and the bonding agreements as these are strongly linked to the deployment process. Definition of the different HR management functions related to deployment are often vague and sometimes difficult to identify. Regarding the four functions studied here we understand recruitment as the process of searching for personnel to enter a particular job or position (Joint Learning Initiative 2004) but have also included the additional activities that lead them getting to their first position (selection, appointment to the organisation, appointment to initial post, induction and probation), bonding as the period of compulsory service that government sponsored students or professionals agree to serve after completing their education either pre-service or post-graduate, transfer¹ as the movement to another job that is previously established through an approved personnel requisition, has the same salary range and may involve a salary increase and secondment² as the temporary placement of an employee to a different part of the organisation or to another organisation, for a specific purpose and period of time, to the mutual benefit of all parties. These functions are represented in Figure 1 below.

Each of these HRM functions are governed by relevant policies and rules. For example, to ensure mobility of staff the, Ghana Health Service has a rule that “*No one person shall be*

¹ <https://hrnt.jhu.edu/pol-man/section/section4.cfm>

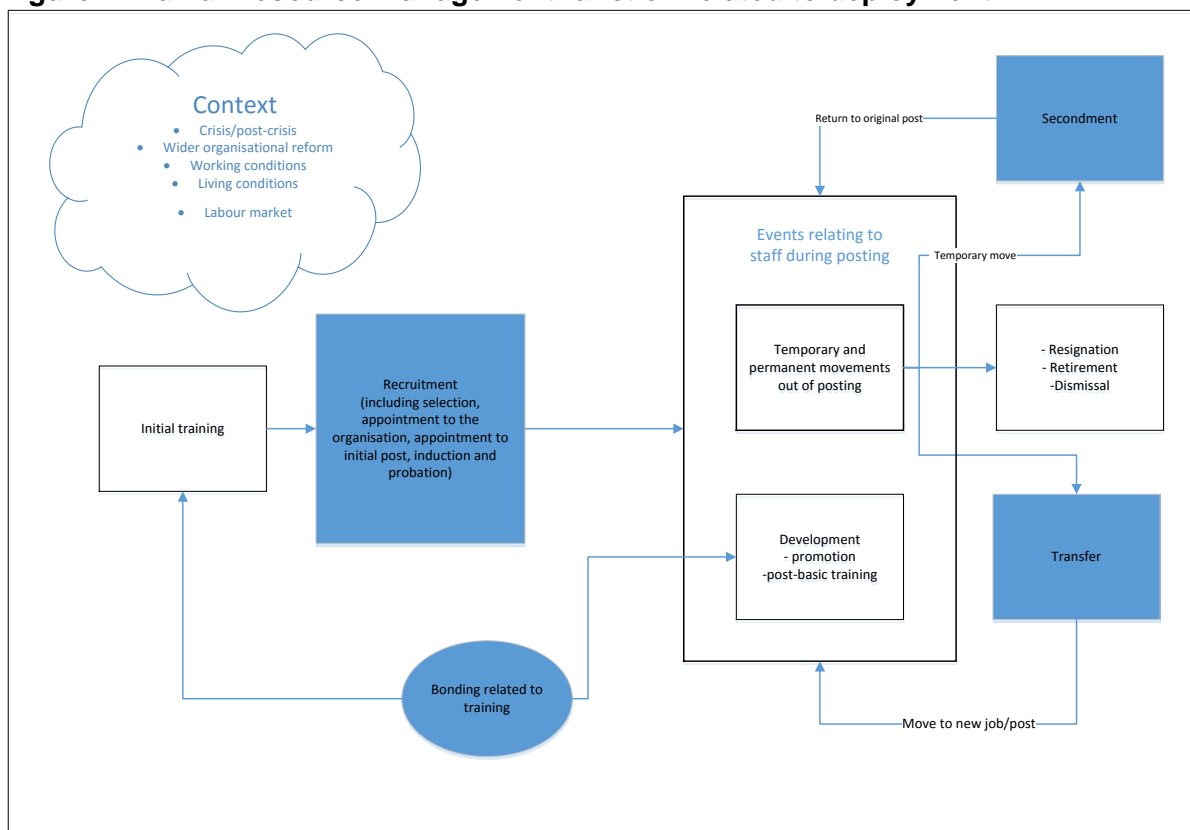
²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/314163/SECONDMENT_POL_ICYV3-SEPT_08_1_.pdf

allowed to stay at a (new) post for more than four years continuous” (Human Resource Division 1997). If government funds the initial training of employees, there will be rules governing initial deployment of graduates which may include a bonding arrangement (Frehywot et al 2010).

The implementation of deployment policies relies on the authority of those who manage the systems. The levels of authority may differ according to the type of staff. For example, in some countries doctors can only be posted by a central authority while lower grade cadres such as nurses may be posted at regional level. In decentralised organisational structures or where responsibility for service delivery has been devolved to local government, responsibilities for posting may be at district level.

Figure 1: Human resource management function related to deployment



As with the translation of any policies into action, the effectiveness of the policy will depend on the “implementation fidelity” of the relevant human resource management systems (Patterson et al, 2010). There is evidence in the public sector in both high and lower income countries that the HR systems related to deployment can be inefficient (Davidson 2010, Vujicic 2009). There is an increasing use of incentives to support deployment of staff to rural areas (WHO 2010) that would be administered as part of the deployment system. Zimbabwe, introduced a rural allowance since the 1990s, to improve rural posting and retention of health

workers. Findings from a second ReBUILD study on health worker incentives and retention, show that rural staffing did not improve because the amount of rural allowances paid was too low and the allowance was eroded by hyperinflation during the crisis (Chirwa et al 2015a, 2015b, 2016). As with all administrative systems, there are also sanctions developed to ensure compliance with the deployment regulations. For example, in Nepal grounds for dismissal from service include: “If he or she does not serve for the period as specified [elsewhere in the regulations]” (Nepal Law Commission, 2010). The deployment system will include the appropriate management of these incentives and sanctions.

Because of the importance to individuals of getting jobs in preferred locations (for personal or family reasons), implementation of the deployment policies according to the specified rules may come under pressure through patronage (Lewis, 2009). This will of course undermine the objectives of the deployment policies and systems, which usually include increasing equitable access to health services.

Little research has been done on the specific HR systems for staff deployment in low and middle income countries. Collins et al (2000) in Pakistan found that deployment systems were not sufficiently robust to withstand the pressures of political patronage. In the education sector in Ghana Hedges et al found that as well as manipulation of the posting system by those who had influence, many new teachers simply did not report to their postings if they did not like them (Hedges, 2007). Sometimes there are not specific policies on deployment which leaves this important function at the criteria of HR managers who can be perceived as arbitrary when making decisions in this regard (Purohit et al 2016a). Other mechanisms such as standard procedures or rules sometimes are introduced with sometimes suboptimal results in terms of promoting transparency and equity (Purohit et al 2016b; Schaaf et al. 2015). Besides leaving this HR management function weakly regulated can have further consequences in terms of credibility of the government administration (Sheikh et al. 2015).

In countries recovering from conflict or crisis, staffing problems normally found in low and middle income countries may be exacerbated. Geographical imbalance of health workers between urban and rural settings is found in post conflict settings (Varpillah et al 2011; Newbrander, 2007). An indication of the weakness of the systems after conflict or crisis is demonstrated by the rise in the number of ghost workers (Pavignani, 2011). This is partly due to the collapse of information systems, including loss or weak capacity of those concerned with collecting personnel data (Waters, 2007). We found no specific references to deployment policies and systems in the health sector post conflict/post crisis literature (Roome et al 2014), though one paper indicates that the recovery phase also may provide opportunities for not

only rebuilding systems but also correcting problems that existed before the conflict or crisis (Alonso et al 2006).

The Republic of Zimbabwe's health system is superintended by the Ministry of Health and Child Care (MoHCC). The MoHCC is involved in direct provision of health care but also regulates other providers. The Public Health Act (Chapter15:09) (1924) (GoZ 1924) spells out the roles of the MoHCC and its relationship with other ministries including Ministry of Local Government, Ministry of Higher and Tertiary Education (MoHTE), Ministry of Education, Sport and Culture (MoESC), Ministry of Defence, Ministry of Home Affairs and the Prison Service who are stakeholders in health service provision either as providers for their various constituents or through training and production of health professionals as is the case with the MoHTE.

Government health services in hospitals and clinics are managed directly by provincial and district medical offices. Rural District Councils (RDCs) and Urban Local Authorities (Municipalities) provide services through their own health centres and clinics and oversight is provided by the Ministry of local and urban development. (WHO, 2009). The Zimbabwe Association of Church Related Hospitals (ZACH) represents Faith Based Organisation (FBO) managed hospitals and liaises with the MoHCC on issues related to health and the health workforce in the faith based health facilities. Church related hospitals account for 23% of health care delivery nationally. There are one hundred and twenty-six church related health facilities in Zimbabwe, and fifty -six of these facilities are owned by the Catholic church. Most the FBO facilities are in rural areas (Mudyarabikwa and Mbengwa 2006: 5, Chandiwana and Nkomo 2001) The FBO sector or church related providers comprise highly differentiated religious denominations, each with its administrative structures, but ZACH provides a unified approach to health service provision by all FBO providers (ZACH, 2009; 2010, 2011). The government introduced service level agreements with FBO providers. However, in 2009 the National Strategic Health Plan 2009-2013 reports that these agreements had only been agreed in but only implemented in Matabeleland North, Mashonaland West and East provinces (MoHCW 2009). Workforce financing is done through block grants to fund staffing by health workers and operational costs (GoZ, 1986, 2009; Sanders, 1990).

a. Background to the situation in Zimbabwe

Zimbabwe experienced a decade of severe economic, social and political crisis between 1997 and 2008. The period from Zimbabwe's independence in 1980 and the beginning of the crisis in 1997 was characterised by rapid expansion and improved access to health services for the population (GoZ 1981, Chimbari, 2008, GoZ, 2009, ZIMSTAT, 2012). During this period there

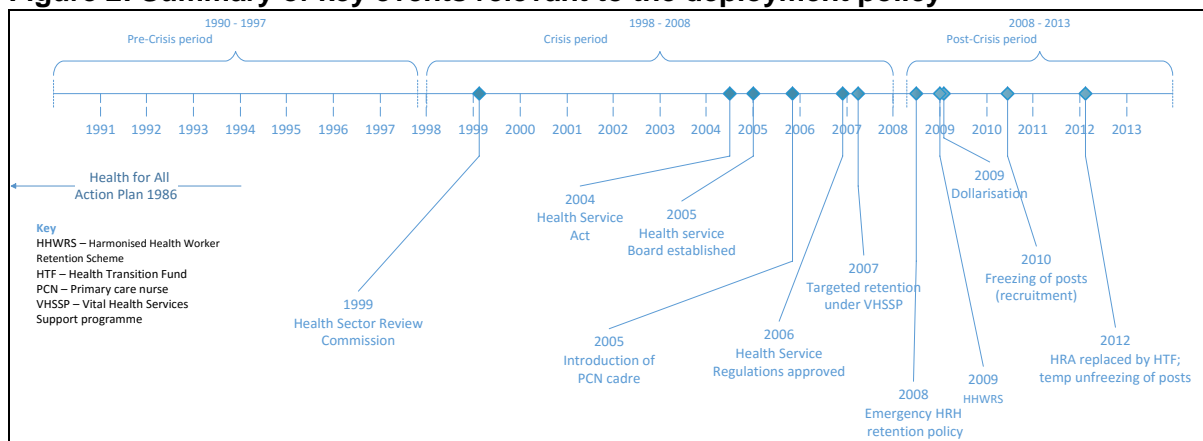
was a strong drive to promote equity to compensate for the skewed health systems developed during the colonial period characterised by racial discrimination in which there was unequal access for citizens of different races. The government, in this regard, proclaimed a policy of unification in 1984 through the white paper, 'planning for equity in health' (GoZ, 1984). However, the crisis caused a deterioration of the health system which led to a reversal of previous gains made in key health indicators including immunization, maternal mortality or infant mortality (GoZ 2010; GoZ 2009; GoZ, 2012 ZIMSTAT and ICF International, 2012). Between 1996 and 2006, Zimbabwe's GDP declined by 37 percent (GoZ 2007). This inevitably had an impact on government funding of the health service and staffing budgets. In 2008 human workforce spending accounted for 0.3% of the public health budget (Osika et al, 2010). Attrition due to migration of health workers was already a problem before the crisis (Sikhosana, 2005; Chikanda 2005), but the staffing situation in the period 2000 to 2009 worsened against a back drop of a shrinking economy and a highly polarised political environment (GoZ, 2009, MoHCW, 2009, MoHCW & HSB 2010b).

Various measures were taken to address the staffing problems. The introduction in 2005 of the Primary Care Nurse (PCN) was a strategy to address staffing problems in rural areas as these 18-month trained health workers would be posted in these more remote areas (MoHCW & HSB 2010a, 2010b). Salary top-ups were paid to 184 district health executives in 24 district/mission hospitals from December 2007 to December 2008 under the Vital Health Services Support Programme (VHSSP) (Dieleman et al 2012). The formation of a coalition government between the two main political parties ZANUPF and MDC helped improve relations with development partners who agreed to once more support various initiatives in the health sector. An emergency measure to pay salary to health workers supported by development partners in 2009 under the Harmonised Health Worker Retention Scheme was implemented (Dieleman et al 2012). This salary top ups were premised on the understanding that as the economy grew after dollarization (the introduction of United States dollar as official currency) in February 2009 the additional payroll costs could be consolidated into government-funded pay rises culminating in a cessation of the emergency salary top ups in 2013 (HSB 2012). These strategies and the recovery of the economy from 2009 onwards helped to attract health workers back to the health service which lead to a temporary stabilisation of the workforce.

The growth of the economy was short-lived and by June 2010 the government, in search of efficiency gains, introduced a recruitment freeze to control the public service wage bill (HSB, 2012). Though the freeze was occasionally temporarily lifted and short windows of hiring were

provided between 2011 and 2013, availability of staff in facilities continued to be inadequate. Nevertheless, vacancy rates for critical health workers including doctors, nurses and midwives, but not pharmacists, progressively fell during the post crisis period 2008–14 (HSB, 2012; World Bank, 2015). In 2009, the country was being served by a public health workforce of approximately 27,840 workers. The medical doctors, pharmacists and nurses to population ratios were estimated at 0.07, 0.03 and 1.35 per 1,000 respectively (MoHCW, 2008, 2009) which is below the minimum WHO standards established by WHO in 2006 (WHO 2006). Zimbabwe was still in the category of countries defined as having a critical shortage of health workers several years later (MacKinnon and MacLaren, 2012). In addition, the disparities in HRH vacancy rates between urban and rural areas and between large government and FBO health facilities is an acknowledged problem in Zimbabwe (Wheeler 2010, HSB 2010).

Figure 2: Summary of key events relevant to the deployment policy



The impact of the crisis on health workers and the responses to mitigate staff shortages took place against a backdrop of organisational change in the health service which originated in the 1980s. The Health for All Action Plan of 1986 was formulated shortly after the country gained independence (GoZ, 1986). The plan, which took forward the concepts of the 1984 paper on planning for equity in health, sought to redress imbalances in the health system by removing all race based inequities and ensuring that every region, district and ward of the country had access to Primary Health Care (PHC). Through the PHC model the Ministry of Health was to coordinate the fragmented providers including FBO hospitals.

Before independence in 1980 the public health sector human resource administration was the responsibility of the Public Service Commission (GoZ, 1983; 2001), though employees of Rural District Councils and FBOs had separate human resource management systems. Nevertheless, the Public Sector Regulations of 2000 (GoZ, 2001) guided the management of

all public service employees. In 1999 the Presidential Health Sector Review Commission (GoZ, 1999) recommended the establishment of a separate body to employ health workers. As a result, the Health Services Board (HSB) was established through the Health Service Act in 2004 (GoZ, 2006. HSB, 2011) to manage the health system in its entirety, avoiding previous fragmentation between the MoHCW and the Ministry of the Public Service (Sikhosana, 2005). Researchers on Zimbabwe's health system contend that the creation of a health service board and not a health service commission, as recommended by the Presidential Review Commission, meant reversion to the status quo ante, whereby the PSC and not the HSB, continues to have the final say on HR issues in the health service (Chimbari, 2008, Sikhosana, 2005). According to the Health Service Act of 2004 the HSB reports to the MoHCW and it *"ensure[s] that the functions vested in it by or under this Act are delegated wherever practicable to hospital management boards and members of the Health Service engaged in public health service delivery"* (Part II, Section 6 (1) (a)) (GoZ 2005). The HSB, in consultation with the MoHCW, is mandated to manage all government-funded health workers. It is therefore responsible for recruitment and deployment, creating grades and setting conditions of service for all government-funded health workers. The Health Service Regulations of 2006 (GoZ, 2006), adapted from the Public Service Regulations of 2000 following the passing of the Health Services Act of 2004, provide guidance for the employment of health workers in government-run health facilities including those run by rural district and urban councils and those run by FBO.

b. Brief Description of ReBUILD and its Objectives

ReBUILD is an international research consortium of academic institutions concerned with research on health system development in post-conflict or post crisis countries. It aims at developing lessons for governments and development agencies on how to make or recreate and sustain fair health systems post crisis. The health workforce is a component of the system that is both greatly affected by crisis or conflict, and essential to the rebuilding of health systems. Rural posting and deployment of health workers is part of the wider ReBUILD portfolio undertaken specifically to explore the effectiveness of deployment systems in Zimbabwe and Uganda in getting and keeping staff in post and ensuring their continuity. How deployment systems for state and non-state employers compare is an important concern for ReBUILD. It is expected that the results of this study can contribute to the attainment of Universal Health Coverage (UHC) in post conflict or post crisis contexts. This study was also carried out by the ReBUILD partner in Uganda. It also complements a second study on the health workforce that ReBUILD conducted on health worker incentives in Zimbabwe, Uganda, Sierra Leone and Cambodia (Witter et al 2012, Chirwa et al, 2014, 2015a, 2015b. 2016).

Research questions and objectives of study

Research questions

- What are the deployment and posting policies in large government and non-government employers of HRH, how and why have they changed during the post-crisis period, and with what impact on equitable staffing of the health systems?
- How do government employers and non-government employers' deployment and posting systems differ and what aspects of the two sectors' systems work effectively and have a positive impact on health delivery?
- What lessons about key decisions regarding deployment and posting systems can we learn in post crisis situations?

Aim

- To identify ways to improve deployment systems to rural areas used by large employers of health personnel post crisis in Zimbabwe and identify lessons for other countries emerging from crisis.

Objectives

- To describe the current deployment practices, policy and systems and how and why they have changed before, during and since the end of the crisis.
- To assess the impact of the key changes in deployment policy and systems on the staffing of rural areas.
- To recommend ways to improve the current system of rural deployment and posting of HRH.
- To identify lessons for other countries about the development of deployment policy and systems in post crisis situations.

Structure of remainder of the report

The next section describes the methods used in this research and details the selection of districts, provides brief descriptions of the two large providers of health that were studied, and the data collection methods and characteristics of participants and the ethical considerations. The results section presents the findings under two broad themes: 1) the context in which the deployment policies and systems were implemented, and 2) the deployment-related policies: how they changed over time, how they were implemented and what the impact on the staffing of rural areas was. This is followed by a discussion section which analyses the deployment systems with reference to the key research questions. Finally, the report presents conclusions

and a small number of recommendations from the lessons learnt on the deployment of health workers in rural areas.

2. Methods

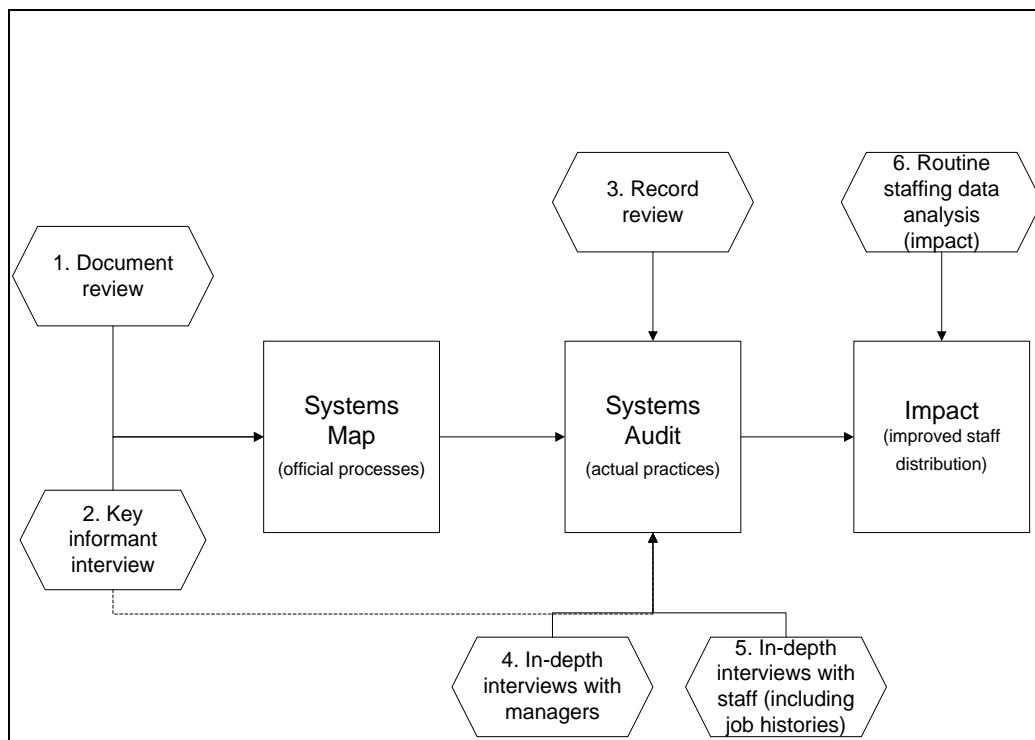
The study was retrospective and identified the deployment policies and systems in Zimbabwe's health sector during the pre-crisis period (1980-1998), crisis period (1999- 2008) and the post crisis period (2009-2014). Both qualitative and quantitative methodologies were used, with the former providing an in-depth investigation and the latter assessing systems consistency of rural posting of the two healthcare providers in three districts. Implementation of deployment policies and systems were examined at district level in facilities managed directly by government and others run by FBOs

a) The Research Design

Six methods were used which included: 1) document and literature review, 2) key informant interviews, 3) personnel record reviews 4) in-depth interviews with managers, 5) in-depth interviews with health workers including job histories and 6) routine staffing data analysis (see Figure 3 below). National policies and systems at different stages in the period under investigation were identified from reviews of documents (method 1) from which initial descriptions and systems maps were developed. These were reviewed in key informant interviews (method 2) to check for accuracy and realism. Contextual factors that had influenced the development of the policies (e.g. broader public sector reforms) or the implementation of the systems were identified both in the document review and the key informant interviews.

The implementation of the deployment systems in rural areas both in the past and currently were "audited" using data collected using three further methods: personnel record review (method 3); in-depth interviews with district level managers who operated the systems (method 4); and in-depth interviews including job histories with health workers to identify the impact of the systems on individuals. Personnel records were used to identify vacancy and turnover rates at different stages of the period under investigation and routine staffing data (method 6) was used to measure the impact of the deployment policies. The quantitative data (methods 3 and 6) was interpreted alongside qualitative data from methods 2, 4 and 5. The research design is summarised in.

Figure 3: Overview of research methods and relationships with deployment systems map and deployment systems audit



b) Description of study sites

The study was carried out in the Midlands province, in three districts referred to numerically in this report as District 1, 2 and 3. The Midlands province had a total population of 1 614 941 in 2012 (ZIMSTAT, 2012). The major providers of health care in the selected districts are government and a large FBO which owns 52% of the faith based hospitals in the country. Government run facilities comprise those owned by local authorities, RDCs and municipalities (GoZ, 1924, 1988, 1997). The province was ideal primarily because it was home to the providers of health care necessary for the study. The districts selected were largely rural with health facilities belonging to government and the large FBO provider. In addition, the districts were selected because travelling to the study sites was easy and within the limits of available resources. District 1 is rural with a population of 80 351. It has three FBO hospitals and one district hospital and several clinics run by the Government. District 2 is fairly balanced, in terms of population distribution, with 175 835 people residing in rural areas and 136 379 in urban areas. There are two large hospitals in the district owned by the large FBO and two large hospitals owned by government including a few health centres and clinics. District 3 is largely rural with some health facilities located in very remote areas. The total population of District 3 was 576 362. Table 1 shows. the distribution of government owned, and the FBO-owned health facilities and the rural component of the population in three districts.

Table 1: Population and numbers of facilities by ownership in study districts

District	Rural population	Government owned health facilities	Health facilities owned by large FBO	Rural District Council facilities
District 1	80,351	6	4	6
District 2	175,835	10	1	15
District 3	576,362	11	9	26

Source: compiled from MoHCW Health Facility List 2010/ ZIMSTATS 2012 Census Report

c) Sample size and sampling

For each data collection tool the sample size was different and the method of sampling was determined according to the data specifications required to answer the set research questions. The specific procedure for sampling and sample sizes are discussed in turn under each data collection method in the field work section.

d) Data collection

The data collection tools included a document review, key informant interview (KII) guide, structured data extraction form for collating personnel records data, in depth interview guide for managers and health coordinators, in depth interview with job histories guide and structured extraction form for collecting routine staffing.

Document review

Desk review was carried out by the senior researchers. An initial list of documents was added on through a snowballing process of following up references and getting recommendations for further reading from the key informant interviews. Analysis of data from document reviews was based on simple content analysis. The main output was a narrative of the evolution including a description of the deployment system at various points in time and an assessment of the rationale for changes to the systems of rural deployment and posting over time in large government and FBO organizations. A total of 76 documents, policies and academic publications were reviewed.

Tool Development

We developed the data collection tools using a collaborative approach. The UK research lead produced generic tools for local adaptation by the ReBUILD Zimbabwe and Uganda teams. The topic guides for the KIIs and IDIs with managers and coordinators, IDI with job histories,

the personnel record and routine staffing data extraction forms were first adapted to the local contextual situation and then refined after pre-testing.

Fieldwork

Pretesting was done in a non-participating district which had similar providers as those in the districts selected for the study. Three researchers carried out the field work for the pretesting of the data collection tools, the international lead, the local lead and a research officer between 21 and 23 August 2013 in Murewa district. The fieldwork was done between March and August 2014 in the three districts. Most of the interviews for the KII, IDI with managers, and IDI with job histories were tape recorded.

Key Informant Interviews

Seventeen key informants from national down to local level for both government and non-government employers were purposively selected according to their knowledge of the focal topics. Additional key informant interviewees were added on recommendation of key informants interviewed. A total of 17 key informant interviews from a planned sample of 20 were conducted at national level. The failure to reach the target of 20 key informants was because the FBO heads of health services in the dioceses indicated that they were unable to participate because they were represented by ZACH and hence it was ZACH that could respond to the policy issues as their link with the MoHCC. The RDC coordinators of health also stated that all matters relating to the health facilities were the responsibility of the MoHCC. See Table 2

Table 2: Number of key informant interviews at National level

Organisation/Sector	Planned Sample	Actual sample by Gender		Actual sample Total
		Male	Female	
Public Sector/HSB	8	8	3	11
Faith Based health sector	3	0	3	3
Health Professions Associations	9	2	1	3
Totals	20	10	7	17

In-depth Interviews with district level deployment managers and coordinators

District level managers were selected from the three study districts. The overall manager and the officer responsible for deployment were selected for interviews. A total of 11 in-depth

interviews were carried out at both government and FBO institutions with deployment managers and coordinator as shown in

Table 3. The overall manager or the officer responsible for deployment for FBOs was selected for interviews. If the manager was very new, a longer-serving member of the management team was selected to provide a historical perspective.

Table 3: Distribution of IDIs with facility managers by sector and gender

Sector	DISTRICT									Grand Totals
	District 1			District 2			District 3			
	Female	Male	Total	Female	Male	Total	Female	Male	Total	
HSB	0	3	3	1	1	2	0	2	2	7
FBO	1	0	1	1	0	2	1	1	2	4
RDC	0	0	0	0	0	0	0	0	0	0
Totals	1	3	4	2	1	3	1	3	4	11

[In-depth Interviews including job histories with health workers](#)

In-depth interviews including job histories with health workers were conducted with three cadres: midwives, general nurses (including registered general nurses, state certified nurses and primary care nurses) and environmental health practitioners - both in the government and in the FBO sectors. A total of 67 health worker interviews were conducted. This was well above the planned sample of 18 IDIs including job histories because the distribution of cadres with the required experience covering the pre-crisis and crisis period was difficult to get especially in Districts 2 and 3. Given resource constraints we interviewed the health workers we found at each facility instead of excluding them as this would have meant revisiting if we could not get the sufficient number of participants. There were no resources both financial and time for second visits. To get useful data we had to increase the sample sizes. See Table 4.

Gender was a key dimension of the study. However, striking a gender balance in the selection of participants was difficult due the predominance of females in the nursing and midwifery professions. Therefore, more females (63%), were interviewed. A mixture of health workers with longer service (at least five years) and newer recruits were selected to give a balance between historical and current information to allow an assessment of consistency and or changes in the deployment system over time. Eleven health workers with less than 5 years (16.4%) and 56 with longer service (83.6%) were interviewed. (See Annex A Job History Summary).

Table 4: In-depth Interviews including job histories with health workers

Sector	Districts									Grand Totals
	District 1			District 2			District 3			
	Female	Male	Total	Female	Male	Total	Female	Male	Total	
HSB	7	3	10	9	6	15	3	6	9	34
FBO	4	1	5	6	2	8	7	2	9	22
RDC	1	1	2	3	2	5	2	2	4	11
Totals	12	5	17	18	10	28	12	14	22	67

Personnel Records

Personnel records for doctors/medical officers (MO), environmental health technicians (EHT), midwives and nurses (e.g. RGN, SIC, PCN and SCN) in government and FBO services were sampled at district level in the three study districts. A planned sample of 10% of personnel records was to be reviewed per district with the exception of doctors whose numbers were not only low at the district level but most of whom had just been deployed or seconded from other districts. The records of the doctors were not at the districts they had been seconded to. The plan was to sample doctors at the provincial level but as routine staffing data at the district shows, personnel records were not available in all three districts. Sampling the personnel files was thus a challenge. The personnel records that were assessed are presented Table 5 below and in annex B in more detail.

Table 5: Sampled personnel record files by district, gender and cadre

Sector	Districts									Grand Totals
	District 1			District 2			District 3			
	Male	Female	Total	Male	Female	Total	Male	Female	Total	
RGN	4	9	13	0	5	5	2	4	6	24
Midwife	1	2	3	2	2	4	0	3	3	10
SIC	0	0	0	1	0	1	0	1	1	2
PCN	0	3	3	0	2	2	0	2	2	7
SCN	1	1	2	0	2	2	0	2	2	6
MO	1	0	1	0	0	0	0	0	0	1
EHT	0	0	0	1	0	1	0	0	0	1
Totals	7	15	22	4	11	15	2	12	14	51

Routine staffing data

Routine staffing data was collected for doctors, environmental health practitioners, midwives and nurses in the three study districts. The data was collected by number of established posts and filled posts by cadre and facility in all districts based on annual staffing returns. The data

were collated by year for the period 2010 to 2013 using structured data extraction forms from the HRH returns retained at the district offices. The routine staffing extraction forms collected absolute numbers of cadres as captured in the copies staff returns retained at the district or facility.

e) Data analysis

The recordings from KIIs, IDIs with managers, and IDIs with job histories were transcribed verbatim and checked for accuracy by the local research team. Further quality control of transcriptions was done by the UK lead researcher. All documents were then uploaded to NVIVO qualitative analysis software (Version 10). A coding framework was developed by the local research team with support from the UK lead, based on the key research questions. All transcriptions were coded using the developed framework. Query reports were developed to extract the data by parent and child node by district, and by type of health provider for the three qualitative tools. The queries were summarized and supporting quotes were provided. These were then synthesized to a report outlining findings and recommendations. The job history time lines were entered into Excel then analyzed using STATA version 12. Personnel records and routine staffing data were entered into Excel and analyzed. Table 5 shows personnel record files that were sampled in the three districts.

f) Research ethics

The protocol for the study was granted approval by the Biomedical Research and Training Institutional review board on 13th June 2012. Ethical permission was obtained from the Medical Research Council of Zimbabwe (MRCZ) on 2 January 2013 (Ref No MRCZ/A/1688). Further review was done by the Research Council of Zimbabwe (RCZ) as is required with all research involving collaboration with international partners. The study was also approved by the Liverpool School of Tropical Medicine,

Participants were informed about the objectives of the study, why they had been chosen, and the risks and benefits of participating in the study before the interviews. The participants were afforded the opportunity to ask questions or make comments and then decide to participate. An information leaflet was provided to all participants through the head of the institutions they were affiliated to before data were collected. A consent form which participants were asked to read before the interview also provided further information. The participant then decided to participate voluntarily and was asked to sign two consent forms. The participants were assured that the whole process would uphold the highest standards of confidentiality and that their participation would be anonymised. One copy of the signed consent form was given to the

participant for their record and the researcher retained another copy to be kept with all other research records securely in a locked room only accessible to the lead researcher.

Some aspects of the investigation were straightforward and uncontroversial. However high levels of confidentiality should be maintained right through the report writing purpose to ensure that responses cannot be traced back to the participants. In this regard the districts, name of training facilities, participant's facility at the time of the interview and other personnel information have been anonymised.

To further ensure that the study was of the highest ethical standards all documents, the protocol, tools for data collection, curriculum vitae of the research team members, participant information sheets and consent forms were reviewed by the BRTI Institutional Review Board and the Medical Research Council of Zimbabwe (MRCZ).

g) Integration of data from different sources

Multiple methods were used to collect data and in the report, we present findings from all the methods. The findings, where relevant, indicate the method that provided data being presented. All data in tabular form are cross referenced with the method from which it derives. Quantitative data from routine staffing, personnel record reviews and job histories were triangulated with qualitative data to measure changes, effects of policies and systems consistency.

3. Results

In this section we present a synthesis from all data sources. In the analysis process the findings fell into two main groups: 1) the context and changes over the study period relevant to the policy and practice of the deployment of health workers in the study settings and 2) the actual changes in the human resource management function related to deployment at policy and implementation levels. Participant responses are presented using a unique reference which describes the type of interview, interview identity number, the gender of the participant, their designation or profession, the sector they are employed, the geographical area where participant practices (national, district 1, 2 or 3).

3.1 Deployment policy context

This section provides findings related to the context in which deployment has taken place during the study period. It starts with a review of the staffing situation in the different health sectors. It then reviews changes in the working and living conditions that are likely to influence

health workers' choice of jobs and employers before reviewing changes in the labour market itself.

Staffing situation

The staffing situation in both the government-run and FBO-run facilities is the result of the number of posts that the government funds and the availability of staff willing and able to take up the posts. As in other sectors the number of funded – or 'established' – posts per health facility have been reduced in line with overall spending cuts rather than increased in line with health service expansion including the provision of services related to HIV/AIDS (Mutizwa-Mangiza 1998) or the upgrading of facilities – for example health centres to hospitals. Mudyarabikwa et al. (2006) contend in their study that:

“Public Services Commission interviews indicated that the last review of health sector establishment was in 1990, but posts were never increased because the IMF and World Bank discouraged it as part of the Economic Structural Adjustment Programme” (p 11)

Wheeler, (2010) suggests that the problem goes back even further:

“...establishments were set around the time of Independence and have never been revised” (page 6)

The government does not use the same classification for grading FBO facilities as is the case with government hospitals, which has implications for staffing establishments. Wheeler (2010) notes that there are different criteria for the determination of FBO hospitals' staff establishments apparent in the difference in staff numbers between government and FBO facilities with the same bed capacity. The ZACH, which coordinates all church related hospitals, asserts that this disparity in establishment posts has to be understood in the context of the arrangements for the employment of staff in FBO facilities. The particular FBO is the employer of the HRH at its facilities and government advances grants that cover recurrent expenditure, including staff salaries, to the FBO through the MoHCW (ZACH, 2010). The disparities in staff establishment between FBO and HSB facilities derives from the grant arrangement with government and the FBOs.

“...so, if we look at district hospitals, like the designated ones [FBO] they will have grades which are equal to those of a government district hospital and the

establishment will..., it's supposed to match that but it's not usually 100% because of the grant limitations so those are the differences" KII 05 Female Manager FBO National

A review by Wheeler (2010) highlights the impact of low establishment levels in FBOs:

"FBO hospitals are under-provided with nursing posts and almost devoid of posts for diagnostic and therapeutic technical support (pharmacy, laboratory, X-ray, dental and physiotherapy." (Page 5)

The government-wide policy of freezing of posts in 2010, initiated by the Ministry of Finance, compounded the problem of the insufficient quantity of established posts. The freeze affected vacancy rates for doctors and EHPs negatively, in spite of the three episodes of the temporary unfreezing in 2011, then in 2012 and 2013. For nursing posts, vacancy rates improved as a result of the temporary unfreezing of posts. The vacancy rates for doctors and EHPs remained precarious in the post crisis period. There was very little change from the crisis period and yet the freeze did not take this unique situation into account; it was a blanket freeze for all posts:

"If you look at our vacancy rates, had it not been for the freeze on recruitment, those posts are easy to fill. You would have challenges in getting doctors at district hospitals but not Nurses and Environmental Health Technicians and officers, so if there are vacant posts it is simply because we do not have the treasury concurrence to replace the vacant posts that are currently there. Having said that I think for areas like [the northern parts of District 3] and other hard to reach areas it will be probably [be] in addition to the rural allowance having a hard to reach area allowance maybe we can say rural allowance but then have various categories." KII 07 Female Manager Gvt National

The staffing data collected in the three districts shows minor variations in the establishment level between 2010 and 2013, but that there were major staff shortages for certain cadres (e.g. 66% vacancy rate for EHPs in District 3 in 2010) (see Table 6).

There was some fluctuation over the years. In the years 2010 and 2011, medical doctor vacancies remained constant, for midwives and nurses the vacancy rate was very high in 2010 but declined in 2011, then rose in 2012 and declined significantly in 2013, for EHPs the vacancy rate, decreased in 2011 rose in 2012 then declined in 2013.

Table 6: Establishments vs Field posts between 2010 and 2013

Districts	Cadre	2010		2011		2012		2013	
		Establishment	In post	Establishment	In post	Establishment	In post	Establishment	In post
District 1	MO	3	1	3	1	3	2	3	2
	EHPs	-	-	17	12	18	12	18	14
	Midwives & Nurses	74	71	74	70	75	70	89	87
District 2	MO	4	0	4	0	4	3	4	3
	EHPs	31	14	31	16	32	16	32	17
	Midwives & Nurses	135	120	131	117	130	113	127	117
District 3	MO	4	4	4	4	4	1	4	3
	Midwives & Nurses	126	111	127	118	127	104	136	125
	EHPs	32	14	32	13	33	12	33	22

There were marginal changes in staffing which might have been a result of short windows of unfreezing to address the issues of replacement of retiring, resigning or transferring cadres. In one case there was even a surplus of one cadre.

"After the crisis, [2009-2013] we did not have staff turnover that much, it only started this year [2014]. All along it was okay. All vacancies were filled and those who were seconded even filled in mission posts." IDI 07 Female Manager FBO District 2

"We must have 50 nurses here but currently [in 2014] they are exceeding the establishment because we received some nurses after the unfreezing of posts was done." IDI 04 Male Manager Gvt District 1

Generally, the combination of low establishments and staff shortages caused managers in the three districts to complain of the difficulty of managing the workload with insufficient staff in the post crisis period.

"If we have at least 20 nurses because nurses here they do night duty and when they do that night duty he/she will be alone on duty manning the male and female wards, maternity ward and the emergencies which is quite difficult for human being to work

under such conditions. At least when they are two it becomes easy as they will be able to communicate and you know during the night there are risks. Also when those nurses go on their nights off they will be a gap on the day staff who will be on duty which is quite difficult for us to run the institution with such a number but I think 20 is an ideal number. Also bearing in mind that we have so many departments which are here at the institution and I think because of the dynamics in health, many things do come and they need to be implemented so I think if we have such a number I think we can share and have a comprehensive package for clients". IDI 10 Male Manager FBO District 3

After the crisis the staffing situation, and therefore workload, temporarily improved as posts were filled by the returning health workers. There was a general amnesty for health workers who had left to re-join despite having resigned, absconded or emigrated.

"From 2007 to 2012 there was no doctor at the District Hospital [in District 1] because of the brain drain but now there is a doctor. The DMO who was there also left and all the DMOs were resident at [two FBO hospitals in District 1]. Majority were clinical officers." [at the time fieldwork was done all the clinical officers were no longer in post in District 1] IDI 02 Male Manager Gvt District 1

"...we had a challenge [members] who had left the ministry of health, during that time they [health workers] were now coming back so there was now need for that circular reappointment of 2009 March which stated that everyone who had left his/her job was now able to come back to work on condition that that person had not committed any crime like theft, fraud or anything else that was not allowed at work, but if someone absconded or resigned the person was able to come back." IDI 08 Male Manager Gvt District 3

Another challenge that has been raised is the gradual loss of skills by cadres that are seconded to new programmes being introduced as they will be exposed to a limited scope of work for long periods and lose adeptness in the other critical areas.

"Yeah I think like these programmes they also bring shortages in the hospital because for example the male circumcision the same people are supposed to be on the roster, and if you do not train more nurses to work on that [MC] programme you will have the same people going and you will have problems and it will have real impact on the

knowledge and skills of that cadre who will be going because they will completely forget whether they are midwives or whatever, they will completely forget and think of male circumcision alone." IDI 06 Female Manager Gvt District 2

Working conditions

The term 'working conditions' encompasses factors relating to the general environment health workers execute their duties in. Working conditions like remuneration, workload, availability of medicines, supervision and support, which are directly linked to the employer, impact more on performance than the conditions that are less directly linked to the employer. General working conditions include availability of amenities, transport links, telecommunications and entertainment which go beyond the responsibilities of the health sector.

The combination of the inadequate number of established posts, vacancies and increasing service provision inevitably leads to higher workload. Complaints about this situation have been voiced by health workers in the previous section.

The general working conditions were unsatisfactory and this was a contributing factor to health worker dissatisfaction. Infrastructure refurbishment at most facilities was hampered by lack of finances stemming from the economic meltdown. Without the necessary maintenance, some facility buildings and housing units for staff were dilapidated with some presenting serious structural problems such as dilapidation of ceilings which was a common feature in buildings. This differed from one facility to another due to the age of buildings. During the crisis these issues were quite important for health workers and after the crisis a lot of refurbishment has been done.

"...When I went there [the new hospital where I intended to transfer to] I compared the hospital and this hospital [the District Hospital in District 3] looked better and also I had to look for accommodation [at the new post]. I started looking for accommodation but I could not find it... ...There is need for renovations here and there. You will find that in most of these houses, taps are leaking here and ceilings are falling. Probably they are old, I don't know, they need renovations" JH 46 Female Nurse Gvt District 3

Transport also affects timely posting of cadres to facilities with the district medical directorate being forced to provide transport for cadres posted to the remotest parts to enable them to carry essential goods for their upkeep at the facilities.

“Yeah the district transferred me with their car to [new clinic in one of the more remote areas in [District 3] in 2009 although some of my things ended up perishing there, because there was no car that was going that side. Some of the things I had to carry them by bus and some things I donated to other people”. JH 64 Female Nurse District 3

Public health work, the domain of EHTs in the communities, is reliant on mobility which means motor cycles and bicycles are needed at all times to maintain functionality of the cadre. However, few cadres have been provided with the necessary transport resulting in some work not being done. Environmental health senior managers claim that funds raised through their activities is not reverting into preventative services but rather towards curative care. They would like these funds to help improve the working conditions of Environmental Health Practitioners such as infrastructure maintenance, transport or uniforms.

“Yeah, the major issue in rural areas is to do with transport, like to us environmental health practitioners mostly we are given motor cycles but it’s not all of us who are given them. Here in [District 3] almost 50 to 60 percent do not have the bicycles. So those are some of the improvements that I think will help if someone is going because you might go to other clinics, like the way [District 3] is you might be deployed in clinics which are about 120 or 130km” without transport, so if you have a motor cycle there will communicate with you calling you for workshops you will be able to attend workshops and meetings, things” JH 54 Female Nurse Gvt District 3

An important part of working conditions, particularly in times of economic crisis, is getting paid in a timely fashion. Following their appointment, the health worker should be able to begin getting their salary within two months. The human resources department at government facilities indicated that they monitor the issue of salaries diligently by checking on the pay sheet and if the pay is not appearing queries are conveyed to the province. If the salary is effected, the HR office will also report to the province that the salary of the health worker is now being paid.

“Yes, so it means that for the next 2 months the person must have salary, so we have to check if the salary has been deposited into the account and if the salary is not in we then check with the province the time when we do our pay sheet until the salary comes. If the person receives the salary, we will then report again to the province that the person is now getting his salary” IDI 08 Male Manager Gvt District 3

However, during the crisis the period it took for a newly appointed cadre to begin drawing the salary was interminably long. The health worker will have to survive on borrowings during that period and this may be difficult in the prevailing economic environment.

“I was given accommodation and I stayed there during my induction training and waiting for my salary for 3 months, when I got my salary, it even disturbed us with my family because the money took some time to come and my family was in need of money...” JH 66 Male EHP Gvt District 3

Living conditions

Transport, good roads and communication networks are a vital component of the living conditions. During the crisis health workers in the three districts mentioned that transport presented challenges because it was expensive generally but in District 3 poor roads were an additional challenge. Health workers cited unavailability of transport as the main reason most cadres were unwilling to accept posts in areas with transport challenges. In District 3, which is very remote compared to District 1 and 2, respondents were unhappy about the transport services especially during the rainy season as travelling to the main commercial centres and nearest towns to get salaries and basic goods was a challenge and they could spend some days travelling to and from. For some cadres in the remotest facilities transport is costly and also one has to devote a full day travelling the short distance to and from town.

“Yeah I think the issue of transport is a challenge, it is very bad. This is the only time of the year [August] when we have stable transport but at times one has to leave at around 4 or 5 am in order to get transport to go to [District 3] and you have to wait there till late afternoon to get transport back here. So transport is the major challenge this side...” IDI 11 Female Manager FBO District 3

At one FBO facility management used to provide transport on pay-days during the crisis and health workers greatly appreciated this. However, starting in 2009 the transport facility was discontinued and the reasons offered were that the available form of transport required a minimum of twenty people which was well above the complement of staff at the facility. The cessation of the provision of transport constitutes a major setback in terms of motivation and retention of health workers at the facility as one health worker said:

“For example our pay day was yesterday but because of the shortage of staff we cannot go and withdraw our money we have to wait until we get off days. During the

rainy season it is even more difficult to get transport and if you get the transport it will be expensive. The hospital used to give us an ambulance but they have since stopped because they said people were now damaging the car by putting heavy things. We were later given a lorry but there was a condition that it would only ferry at least 20 people. As I said earlier we are only 13 here so we never used the lorry because our numbers would not get to 20. During this season it is okay. We have come to accept our situation and we have learnt to live like this". JH 63 Female Nurse FBO District 3

Shelter, food, access to clean water, availability of electricity and safety play an important role in the attraction and retention of health workers. Living conditions of health workers deteriorated remarkably during the economic meltdown crisis. In the HSB sector dilapidation of staff housing was apparent. There were critical shortages of accommodation at some facilities and if the accommodation was available it was in a bad state. Nothing much was done with regards to refurbishing of infrastructure at some rural facilities due to lack of finances.

"When the RGNs refused to go to the rural areas it was because of the dilapidation of the infrastructure and poor living conditions. There is need to improve and refurbish the clinics." IDI 01 Male Manager Gvt District 1

Poor living conditions made life more and more difficult for health workers who were already challenged by the economic crisis and this led to some health workers leaving their jobs or transferring. On the other hand, the FBO sector managed to attract and retain its workers better because they offered good accommodation and food to their workers during the crisis.

"...during crisis period ... the church in 2008 when there was drought the Bishop managed to send us food stuffs which we distributed to our members of staff and there is a school nearby those with kids can easily send their children to our mission school so in that case there is no problem. Also when it is a pay day sometimes when things were ok we used to be provided with transport for our staff to go and get their salaries at [District 3]" IDI 11 Female Manager FBO District 3.

The security of health workers during the crisis was compromised in some areas of the country. Politically originated incidents were sometimes representing a threat to the security of health workers. Also some participants reported security problems caused by local youth.

There were instances where health workers were being mobilised for political meetings after work. Health workers also felt unsafe staying in some disadvantaged locations (e.g. low income residential areas in the urban areas) and were safer at the health facilities during working hours.

“What we did was to gather our staff and let them know that as health workers they were not supposed to be involved in political issues. We also told them that they could not do it here at work but if they decide to be involved after work it was up to them or if they wanted to do it in their home districts it was up to them. At work everyone was supposed to be treated equally regardless of their political affiliation. We also gathered the village heads when some boys had come here marching and making noise, trying to frighten us and were demanding to see some of our staff. Our staff had to hide in cupboards leaving the patients alone. This was very disturbing so we called the community leaders and we addressed them and also went to the police and told them that if this keeps going on the staff especially nurses who were not from the community may decide to go back to their home districts and the hospital will be left without nurses. What will the patients do? We told the community leaders that these boys who were coming here to kick doors and windows were from the community and they should take care of them so that they don't come here. We told them that the hospital was there to serve them so if they frighten nurses and they run away then it meant the community was in trouble because there will no- one to attend to them when they fall sick and if someone comes bleeding at night they would die because there will be no- one to attend to them. We addressed the staff and the community leaders” IDI 07 Female Manager FBO District 2

According to some FBO managers in District 3 the security of some health cadres in the FBO sector was not affected during the crisis as some managers enforced the rule that health workers were to be apolitical. In one of the districts a health worker was transferred because of the security situation.

“Remember when this crisis came, it came with certain political problems and in some areas government workers, teachers and so on, were targeted and in some areas teachers ran away leaving the schools. In the health sector we didn't hear of any such situations [...] we have a contract form which is signed by either a seconded or the one on our establishment, it states that no member of staff is supposed to be involved in politics here at the hospital premises so I think it's one area already one knows

what he/she is supposed to do as far as politics is concerned” ” IDI 11 Female Manager FBO District 3.

In most FBOs the living conditions that were presented as a pull factor do not meet the expectations of the cadres who are posted. This is probably because FBOs provide services often in more remote and rural areas. Furthermore, the other conditions imposed by the FBO management that are in place including obligation to introduce all workers’ visitors to the sisters, playing your radio at a very low level, was perceived as impinging personal freedoms by cadres who pointed out that it is only the difficulties with respect to transfers which is stopping them from leaving.

“...There is no freedom here like in government institutions. There are restrictions even in playing your radio, the volume should always be low and when you have visitors you are supposed to go and introduce them to the sisters...” JH 63 Female Nurse FBO District 3

Labour market

A labour market is a structure for allowing labour services to be bought and sold, or as McPake et al (2013) say, “rented”. Health workers will look at what employers are offering in terms of salary, other benefits, convenience, etc. Employers will normally aim to offer a competitive package, but will be constrained by finances and, in the case of government, cross-government pay scales. Health workers may look to other sectors or other countries to find work. The mix of benefits wanted by health workers and what employers can offer may vary according to changes in the wider context – and in the case of this study, the context of the economic crisis and the post crisis period as described above.

The range of employers at district level include government run services including those run by the Rural District Councils; the municipalities; the FBOs; NGOs, the private health sector, other national non-health employers and overseas health and non-health employers.

Public sector

Prior to the economic crisis health workers were resigning from the public sector due to poor terms and conditions. Salaries were low and their living standards were in terminal decline (Sikhosana, 2005). The crisis worsened the situation and health workers left their posts either to get employed elsewhere in the health sector or to take up work in other sectors.

The shift from Public Service Commission to HSB seems initially to have had a positive impact on the condition of health workers. However, managers reported that they were no longer getting more than any other civil servant as it used to be and it seems from data that the autonomy that HSB should have had to make decisions about the workforce is not actually present as HSB still needs to consult with Ministry of Finance (MoF) for main decisions. This was also confirmed by human resource personnel at district hospitals who reported that there were no significant changes in terms of conditions since the envisaged differences from civil servants in other sectors never materialized.

“That had improved the conditions of HRH quite significantly but in terms of implementation there are some challenges; there is still a lot to do for example HSB still gets a nod from the Ministry of Finance. It came up with more allowances for the health workers for example the locum allowance. We know that health workers used to receive higher salaries; 25% more than the rest of the government workers but now they are getting the same salaries as others.” KII 01 Male Manager Gvt Provincial

While salaries are supposed to be equal for FBO and HSB workers the reality is that the FBO are paid less overall (salary and allowances) than their counterpart occupying a similar grade in the HSB, as this manager suggested.

“...salaries of Mission health workers are determined by government based on the grades which are supposed to be at that level. If there is a matron 3 her salary will be matron 3 and is the same salary as for the government. However, the difference will be on other benefits which then make the salary of that matron not equal to that of the government whereby there are certain allowances which are given to a government employee but not so much to eeh Mission hospital because of the grant limitations. So the salaries are the same, the grades are same but the benefits differ hence the differences in salaries so that’s why people say aah I am not paid like the other person but I am doing a lot of work so that’s the situation at the moment, so that is one key area.” KII 05 Female Manager FBO National

In the post crisis period health workers felt they were not being paid what they are worth and this means that the push to leave remained a patent threat. The factors that fuelled the brain drain during the crisis persist and are seemingly re-emerging.

“There was a time when health workers felt they were comfortable with what they were earning. It was almost equivalent to what they believe they should be getting

and I think it's acknowledged that right now the government is not paying all its workers what they are worth. So, that will be the starting point; pay all workers what they are worth; then the rest is now to the various employers to bring one or two incentives or ummm carrots to retain the workers that they have." KII 07 Female Manager Gvt National

After the crisis in 2009 an additional incentive, the "Harmonised Retention Allowance" (HRA), was introduced with funding from the Global Fund Health Systems Strengthening component Round 8 (HSB, 2011). For the first three months it was reported that all cadres regardless of their grade were receiving this allowance but after that period it was restricted to those on grade C5 (PCNs) and above which was a blow to the lower graded cadres, mostly nurse aides, cleaners, cooks, etc., who got demotivated. Another allowance was introduced after the HRA which was termed the Health Transition Fund 1 (HTF3) which supports all the health cadres in grade C5 and above. Some managers at district level thought the HTF was meant for midwives only and there were reports that it was causing commotion within the facilities.

"Then the same applies to this HTF, it's now within the same group now with the others not getting the allowance. You will find that, once we have people being paid, for that person to serve, it would have been a chain of events. The driver goes and collects the patient but only that one who has delivered is said to be paid so the drivers as an example are now saying, "why don't we also get this HTF allowance, we are also in this midwifery thing by mere taking of the pregnant mother from the rural area to the hospital". Then the same goes for the cleaners and even within the nurses themselves they feel it is a discriminatory thing. Otherwise the HTF itself has caused some sort of commotions and you will find that there is this tendency of thinking that these people are more looked upon than the other cadres but if you look at the work itself, it involves everyone from administration. It would have been proper if this allowance was paid proportionally, not equally but at least everyone was supposed to benefit just like what happened when the retention allowance was introduced, it would motivate staff". IDI 05 Male Manager Gvt District 2

Municipalities

³ Named after the Health Transition Fund which funded, among other things, this allowance

The immediate destination for health workers leaving the public health sector were the municipal health providers. The Chinhoyi municipality, for example, were paying one and a half times more than the HSB from additional funds generated through user fees.

"...[In] Chinhoyi town directors [of health departments] get about \$1,500 but what I know is [the salaries of the health department in Chinhoyi town] are usually one and half more than the government [salaries] ...They are [taking workers from the government] but at least that is internal migration, usually we train the health workers and they gain experience and they move to local authorities but what do we do?" KII 06 Male Manager Gvt National

Faith-based organisations

As reported above, salaries are supposed to be equal for FBO and HSB health workers but it seemed that these in the HSB sector had some allowances that are not paid in the FBO sector as this manager suggested.

"...salaries of Mission health workers are determined by government based on the grades which are supposed to be at that level. If there is a matron 3 her salary will be matron 3 and is the same salary as for the government. However, the difference will be on other benefits which then make the salary of that matron not equal to that of the government whereby there are certain allowances which are given to a government employee but not so much to Mission hospital because of the grant limitations." KII 05 Female Manager FBO National

Some Managers in the FBO sector felt that workload in the Government sector was less compared to the FBO sector but the salaries for health workers in the FBOs were not linked to workload. They suggested paying health workers according to their qualifications.

Outreach programmes run in FBO facilities were reported to be removing staff from working at their work stations so that they go into the community. These cadres would receive some allowances for this activity. These programmes were reported to increase the workload for staff who remained behind working at facilities but this was tolerated for the financial benefits which cadres would get from participating.

"Removing one nurse who goes into the community will increase staff shortages but we cannot say no because the programme benefits our staff since they get some allowances." IDI 07 Female Manager FBO District 2

Some cadres in the FBO sector who were promoted did not receive any salary increases for close to ten years.

“I have been a sister in charge for some time now but there is no extra something.... It was in 2003, when I came here at Holy Cross I was coming from the interview. So in September 2003 that is when I received the letter.” JH 11 Female Midwife FBO District 1

Non-government organisations

A second destination for government health workers was to the Non-Governmental Organisation (NGO) sector.

“Attrition was from the government to NGOs” KII 03 Male Manager Gvt National

“What happens is if there is a NGO that wants EHTs, I can leave the Ministry of Health...But if there is an NGO that needs EHT I will be the first one to leave.”

JH 32 Male EHP Gvt Male District 2

The private-for-profit health sector

Some staff left to work in the private sector where the money was better:

“Yes that's a private clinic, it was partially to do with the remuneration to be frank; the private sector was paying better salaries than the government, so when I applied they were impressed by what I presented and they took me on board.” JH 27 Male Nurse Gvt District 2

Another option was to keep the government job, but to work part time in the private sector – what is known as “dual practice”.

“In government they apply to do locum where they can get extra money or locum allowances, have seen nurses going to private hospitals like St Anne's hospital and Avenues clinic in Harare for locums. But what we see is fatigue and usually the health worker gives maximum effort where he/she is paid; well, that is the private. Long back we were not allowed to do locums but we used to be paid well. At the moment they leave from hand to mouth.” KII 02 Female Manager Gvt Province

Generally, there are no opportunities for dual practice in the rural areas. District 3 in the study is the worst affected as there are just a few opportunities mainly in the district headquarters which is in a nascent urban area.

“In case they are off duty or they are on leave if they want work as locum there are private institutions there and they can work and top up their salaries but here [a rural area] you are not in connection with anybody and there is no private institution anywhere. When you are on leave you sit home and stay. You cannot add anything to your salary.” JH Female Nurse District 3

Non-health sectors

Some health workers went to work in other non-health jobs. In District 3 opportunities to work in health related sectors were quite limited and only professional staff were able to get jobs elsewhere. Some less qualified health workers left their jobs to work in jobs that were not related to health.

“...some PCNs also went outside but they were not doing nursing they were doing anything that was available” IDI 09 Male Manager Gvt District 3

Professional migration

During the crisis many health workers decided to move abroad looking for greener pastures. Despite codes of practice for ethical recruitment to avoid brain drain from areas affected by shortage, including Southern African Development Community protocol, which article 19 calls on member countries to cooperate in the ethical hiring of health workers to control professional migration (SADC, 2010), many staff left the country to work in the region or beyond. For instance, Chikanda (2010) reports that over 24% of Zimbabwean trained nurses were working abroad in 2006. Some participants reported that this problem was more prevalent among staff with higher and more marketable qualifications.

“Eeeeh.....just a few went to local authorities or other departments in Zimbabwe but most of them left for outside countries because in most cases we would hear some people going to South Africa, some people going to New Zealand, Australia, Britain so most of them were going out but few of course will be going to other departments in the country.” IDI 05 Male Manager Gvt District 2

“Maybe I can say professional staff were the ones who were able to move because they were able to get jobs somewhere. Those in the lower grades professionals we just forced ourselves to be at work but for the nurses you would hear that someone has gone to Botswana, someone to South Africa” IDI 08 Male Manager Gvt District 3

Some health workers who had left at the height of the crisis returned in the immediate post crisis period. However, some senior nurses were hesitating to come back as the recovery was not evident and they heard that not all of them were able to re-join the workforce; it was reported that many preferred to wait until they assessed what was happening with those who returned. Vacant posts were initially filled up, nevertheless, with returning health workers and the newly graduated health workers.

“Some health workers who are still in the diaspora but desiring to come back are sceptical about the post crisis recovery and are getting information from those that have returned but are not yet back in employment which discourages them from coming back” IDI 05 Male Manager Gvt District 2

Entry into health professions

In spite of reported staff shortages, some newly graduated nurses who could not find a job after completing their pre-service education due to the recruitment freeze, were forced to look for employment in other sectors outside the government and wait until the posts were unfrozen after the crisis.

“After completing my RGN training the government froze the nursing posts. So, I applied in the private sector and I got a job at a private hospital in [in a district in Masvingo province] and worked there up to December 2010. In January 2011 when the posts were unfrozen, as I was already deployed to Midlands province, I went to check for my deployment status at the PMD’s office and I was told to go to the General Hospital [in District 2].” JH 15 Female Nurse FBO District 1

In summary, there is an insufficient number of established posts in both the government and FBO facilities. This problem was compounded during the crisis as many health workers left the health sector and many went abroad. Staffing shortages and low staff establishments lead to high workloads and contribute to demotivated staff willing to leave. This is a problem particularly in the FBO sector. Deteriorating working conditions, including getting pay in timely

fashion and value of pay, and the precarious living conditions, were contributing to low morale of staff and staff deciding to leave. Some attempts were made to improve the employment conditions including pay for health staff by moving to HSB but benefits were eroded due to the crisis; there were better working conditions, apart from workload, in FBOs, but fewer benefits. All this led to an increase in staff leaving the health sector and migrating overseas during the crisis. Some staff started returning after dollarization in 2009 and the temporary improvement in the economy. However, the rebuilding of the workforce came to a halt with the introduction of the recruitment freeze.

3.2 Human Resource policies, implementation and effects

This section reports on policies and their implementation (practices) of key HR functions related to deployment, namely 1) recruitment, 2) transfer, 3) bonding and 4) secondment (see Figure 1 above).

The main policies dealing with deployment and other processes linked to deployment are the Public Service Regulations (PSR) 2000 and the Health Services Regulations (HSR) 2006 which were developed by HSB after its establishment in 2005.

3.2.1 Recruitment

In this study, as stated in the methods section, we take a broad approach to locate deployment within overall human resources management. Under 'recruitment' we have included policies and practices related to the first job of a health worker i.e. selection of candidates, appointment to the HSB, appointment to initial post, induction and probation.

As already described above, the health sector before independence was fragmented with various actors providing health services for the public. Recruitment of HRH was done by the individual providers. A few years after independence, recruitment changed, as the Ministry of Health implemented the "growth with equity" policy (GoZ, 1981) reflected in the health sector through adoption of the concepts of "Equity in Health" and the "Primary Health care" (Nyazema 2010) which were articulated through the "Health for All Action Plan" (MoHCW, 1986). The HRH management system was centralised with all Government, Rural District Councils, Mission and Municipality providers unified under the national public health system (National Transitional Development Plan 1983, Sanders, 1990). The policy of unification, however, was not consistently implemented across all sectors and provinces. The national health strategy 2009-2013, for instance, acknowledges that service contracts between mission hospitals

(FBO) and MoHCW which were supposed to be implemented nationally had been introduced only in three provinces (MoHCW, 2009).

With the centralisation of recruitment, the Public Service Commission (PSC) became the overall authority responsible for the recruitment of all civil servants but since the establishment of the Health Service Board in 2005, the MoHCC and HSB are responsible for recruitment, posting and deployment of human resources in the health sector as stated in the HSRs 2006. However, the PSC remains the ultimate employer of all civil servants as per HAS 2004 Para. 26(4).

3.2.1.1 Recruitment policies

The Public Service Regulations (2000) sections (2) and (3/1a-d) outline that members are recruited based on knowledge about the task to be performed and ability to perform it, relevant experience, the requisite qualifications and qualities and, where applicable, potential for training and development. The recruitment is done on the basis of merit according to these criteria (GoZ 2000). The policy leaves it up to the PSC to set entrance examinations to ensure that persons recruited meet the requirements of their posts.

Regarding appointment (assigning a post to a new employee), PSR 2000 defines two modalities: 1) indefinite pensionable conditions of service or 2) temporary terms to fill casual vacancies or supernumerary posts. PSC issue notices or circulars governing appointments to any post or grade, including notices or circulars specifying qualifications with respect to knowledge, ability, professional attainment, aptitude and potential.

Every appointment is made by the PSC except those that the Commission delegates to heads of Ministry or heads of department. The principles governing the appointment to the Civil Service are that all eligible candidates shall be considered equally on merit by fair competition under procedures which safeguard against individual bias and the selection criteria and techniques to be applied shall be reliable, valid and relevant to the post concerned.

Candidates should be timeously informed of any vacancy and the conditions of service attaching to it and given a reasonable time within which to apply. Every notice or advertisement inviting applications for appointment to a vacancy in the Public Service shall set out as clearly and concisely as possible the job description and job specification applicable to the vacancy. Before making an offer of appointment the appointing authority shall complete to its satisfaction all the checks necessary to confirm that the candidate is eligible for appointment.

No appointment shall be made, whether temporary or otherwise, for which no provision has been made in the Estimates of Expenditure for the current financial year.

Appointees need to be older than 18 years of age unless appointed as apprentices or cadets. If applicant is fifty years of age or older he or she cannot be appointed on pensionable conditions of service provided that any such person may be appointed on contract for a specified period of service.

There are some cases in which appointment cannot take place unless the PSC expressly approves such appointment in writing. These cases are 1) when somebody has benefited from a voluntary retirement scheme implemented by the PSC, 2) somebody who has been dismissed or called upon to resign from the Public Service within a period of two years preceding the proposed appointment, 3) anybody who has been convicted of a criminal offence for which he has been sentenced to and served a term of imprisonment or 4) anybody who has resigned from the Public Service for personal reasons within a period of one year preceding the proposed appointment.

The appointing authority issues a letter of appointment to the new employee. PSR 2000 provides some important remarks for new employees appointed on pensionable conditions of service such as requesting new employees to devote the whole of their time at the disposal of the State with important implications in terms of regulating dual practice. The policy also indicates the new employee should accept liability to be transferred to any part of the country at any time which directly affects deployment.

In regard to probation (process of testing or observing the character or abilities of a person who is new to a role or job), PSR 2000 defines this period to be not less than one year after which and if satisfactory this person's appointment should be confirmed. In case the member does not meet the required standard of performance, the appointing authority may discharge the member or extend the probationary period by not more than six months, at the end of which period the member shall be discharged if he fails to meet the required standard of performance. Another special case specified in the PSR 2000 is, despite having presented the medical certificate required for recruitment, the appointing authority decides during the probationary period that the member does not meet the required standard of health, or if a member has taken sick leave aggregating to ninety days or more during the probationary period, member will be required to undergo a further medical examination by a medical practitioner approved by the Secretary for Health.

3.2.1.2 Recruitment policy Changes

The Health Service Regulation 2006 brought in some changes in the recruitment policy. Recruitment powers were allocated to the HSB or the Hospital Management Board which, in case of specified posts, the HSB can delegate on the Minister of Health or Head of Department whichever the case may be. Besides merit, HSR 2006 adds “professional and moral standing” as criteria for recruitment. In regard to recruitment of under 18 years of age the new policy adds trainees to the candidates that can be considered for appointment (e.g. apprentices and cadets in PSR 2000) which is important given that most health disciplines include relatively long periods of internships as an important element of their education programmes which included trainees under the age of 18.

The new policy retains the terms regulating dual practice demanding that all candidates appointed on pensionable conditions of service shall devote all of their time to the State but adds to it that this full dedication to public service can be waived by the HSB allowing specifically authorised workers to devote part of their time to private practice. This opens new opportunities to address the high attrition from the public to the private sector observed after independence (Lowenson et al 1991).

In regard to probation the new regulation (HSR 2006) reduces the minimum probationary period from one year to six months, but allows the extension of another six months in case of underperformance.

3.2.1.3 Implementation of recruitment policies in the Public sector/HSB

During the early years of independence, there were very few government health facilities in rural areas due to the legacy of the pre-independence racial policies that promoted separate health services for the different races. Health services were concentrated where white Zimbabweans were living which was mostly in urban settings (GoZ 1986, Sanders 1990, MoHCW 2007, 2009). During the first decade after independence together with an important infrastructure development there was an important quantitative expansion of the health workforce with education institutions increasing substantially their intakes. However, as availability of health professionals increased so did the attrition of health workers from the public to the private sector resulting in for instance 60% of registered doctors not in government service in 1991 (Lowenson et al 1991)

When the government adopted the policy of integrating the fragmented health sector, recruitment of health workers in the public sector was still not centralised with health workers having to hunt for jobs after pre-service training.

“From 1992 to 1995 I did my nursing training as an RGN at Harare central hospital... we were not being deployed [by MoH]; each person would look for his/her own place...” JH 62 Male Midwife Gvt District 3

Even some health workers who completed their training in 2000, when the PSR 2000 legislation was approved, reported having been directed to hunt for employment by themselves as this male nurse reported

“... I went for the nursing training at Harare school of nursing from 1997 to 2000. After the training I came to District 3 hospital from July 2000 up to now...so after the training we were told that each one of us is free to look for a job anywhere he/she wants.” JH 53 Male Nurse Gvt District 3

Once centralised HRH management was in place newly qualified health workers selected three provinces they preferred to work in after pre-service training. Each graduating health worker had an equal opportunity to be selected to a post based on the preferences they made on the recruitment form filled and submitted to the MoHCC and the HSB.

“Basically when nurses are almost done with their training they are asked to choose three provinces where they prefer to work in. They will then be allocated to provinces according to vacancies that will be available.” IDI 04 Male Manager Gvt District 1

“Towards the end of the training period student nurses are asked to choose three choices that is provinces, they complete forms and those forms are sent to the DNS [Director of Nursing Services] office.” KII 02 Female Manager Gvt Provincial

Once they have been allocated to a province, health workers report to the provincial head of their specific profession (e.g. Provincial Nurse Officer or Provincial Environmental Health Officer) for their initial posting to a particular district. Cadres are then deployed to the districts reporting to the district medical offices where they have been appointed. The district head of each profession and the district human resources departments will have already identified the specific facilities with vacancies to be filled and each cadre will then be informed where to report to start work.

“When they get to the provinces the Provincial Nursing Officer with the help of the Human Resources will then deploy them to the districts. When they get here the DNO

and the HR decide who will go where because I work in concurrence with the DNO since I am the one who knows the establishment. We assist the DNO by telling him where the vacant posts are.” IDI 04 Male HR manager Gvt District 1

The HR department at district level will thoroughly check all the documents to ensure completeness and authenticity. The quality checks of the appointment process will be done at all stages in the different levels, provincial directorate, HSB and MoHCC and Salary Services Bureau (SSB) in the PSC. An important step that has to be done by the HR department is to ascertain the status of the health worker in terms of whether this is an initial posting or a transfer and hence the level at which they are entering the service. Once this process has been completed the health worker will fill in an appointment application into the Zimbabwe health service under the HSB. The health worker will also complete an assumption of duty form and will be checked for criminal records.

“We compile the appointment dossier; we look at.... like say someone has been deployed from the province, the person must have a letter stating that they have been truly deployed from the head office, from the province. Then we look at the documents of that person if she has all the required qualifications, for example practicing certificate if you are a general nurse then academic qualifications, then they will complete an application form, appointment into Zimbabwe [health service], then the person will sign a confidentiality report; after that we will then send the dossier to our province for approval and checks. There will be 4 copies for each dossier. The first copy is for the DMO, second copy for the PMD, third copy is for head office and the fourth copy is for the SSB.” IDI 08 Male Manager Gvt District 3

"Thus when I went to Mberengwa and I then completed assumption of duty or deployment forms and the finger prints were taken in 2009 [Process of checking for criminal record]." JH 30 Female Nurse Gvt District 2

“[I filled in] Assumption of duty forms and then [got] police clearance [checking whether they had a criminal record].” JH 35 Female EHP Gvt District 2

After the assumption of duty workers go through a period of induction also referred to as “familiarisation”.

“Usually, usually, usually after filling in those assumption of duty forms you do what we term familiarisation...” JH 28 Male EHP Govt District 2

Informants reported that induction was provided either in the facility they were posted to or in other facilities in the district.

“I was deployed at District 1 Hospital and I was sent to the Senatorial clinic in Mvuma district for induction [in 2007] ... For 6 months, so I was deployed again. In fact, at Senatorial it was just induction.” JH 06 Female Nurse Govt District 1

“In 2008 I was deployed at District 1 Hospital and I went for induction at Hama Clinic from March to October [10 months] 2008.” JH 07 Female Nurse Govt District 1

However, health workers appointed during the crisis reported that they had received a short induction or none at all.

“There was only one-week induction at [District 3] District Hospital [in 2007] and then I was posted to Nyaje Rural Health Centre” JH 59 Male EHP Gvt District 3

Workers reported that the first salary payment was delayed for several months after assumption of duty

“I was given accommodation and I stayed there [District Hospital] during my induction training [in 2008] and waiting for my salary for 3 months” JH 66 Male EHP Gvt District 3

As explained above, in an attempt to address the problems of understaffing and weak retention of HRH in rural areas, the Government of Zimbabwe developed a new cadre of nurses called Primary Care Nurse in 2005 specifically trained at basic level during 18 months to be posted exclusively in rural areas. The selection of candidates to apply to PCN studies was slightly different to other cadres because preference was given to workers with previous experience in the health sector such as general hands or nurse aides. PCNs were recruited automatically after completion of their studies.

“... alright, when I was working at Munene as a general hand that is when the Issue of PCNs was introduced, it was being said that there is a shortage of nursing staff in Zimbabwe so the government decided to train 18-months nurses, ... They were saying that they wanted nurse aides with five “O” Levels and I was fortunate enough because at that hospital there were not enough staff with five “O” Levels. ... I applied and was called for the interview in Gweru at the PMD’s office. I passed the interview and I was told that I will go to St Theresa in 2005 January 5.” JH 06 Female Nurse Gvt District 1

“...I then joined the Ministry of Health and worked as a general hand at Msilahobe from 2001 to 2003. In 2003 whilst at Msilahobe clinic, I was given a post as a nurse aid and worked as a nurse aid from 2003 to 2004. I went for PCN training...” JH 33MaleNurse Gvt District 2.

Funding of health professional education is covered by the State including tuition and student allowances with the expectation that they will work for government on graduation. Hence selection into the health service actually takes place at the point of entry into training. Training schools set the entry requirements for each profession as stipulated by the professional councils and the MoHCC. In the case of Nursing, Nurses Council of Zimbabwe in addition to entry criteria also tests all students at the end of their education to ensure that appropriate professional standards have been achieved.

“The recruitment [of applicants] is basically the business of Ministry of Health like in this country because; they train almost all the nurses. ...[.]... They are the owners of the training schools but they have their own standards which are acceptable to us because we say for somebody to be trained as a nurse they ought to have done a certain level of secondary school education to be admitted into a nursing training. But the actual recruitment, then Ministry of Health does that for their schools, the Missions [Mission Nurse training schools] also I think they do their bit in conjunction with Ministry of Health and then the nurses are trained and then at the end of the training we then test them to see if they meet the standard.” KII 04 Female Manager Health Professions Association National

“We [Zimbabwe Nursing Council] make sure they [nurses and midwives] are well trained, we approve the schools where they are trained, we approve their curriculum, this is all to do with standards, starting from the course that the nurse the sort of nurse whom we want to be practicing in Zimbabwe or whom we will qualify ourselves and

certify meets these standards and for them to reach that standard, they have to be trained in a certain environment which we approve ourselves, so we inspect the schools, we approve the schools, we approve the courses and then we let the schools train them. At the end of the training we test them ourselves.” KII 04 Female Manager Health Professions Association National

Unlike other cadres, EHPs are recruited for pre-service training from the communities where they will be posted after graduation.

“Normally we advertise for Environmental Health Technicians although some may just register with their districts. We look for people who would have seen an EHT in the districts and who admire the work they [EHPs] do and they apply. So recruitment is done at provincial level, each province will recruit 10 EHTs. So provinces recruit on their own and they manage it [recruitment] themselves.” KII 03 Male Manager Gvt National

“Yes, during the training if you tell them that I come from Midlands they will tell you that that is where you will go. So they were some in Bindura, some in Domboshawa, Gweru and Gwanda but I cannot remember the other institution. So when you complete your studies you will then go to the province and at the province each one will be told where to go.” JH 08 Male EHP Gvt District 1

Using the legal space provided by the HSR 2006 in regard to delegation of recruitment powers to the minister or head of department (HSR 2006 Section 6/3) the selection of doctors for deployment is done by the ministry at head office after the newly graduated doctors have filled in the recruitment forms. Most doctors prefer posts in Harare, the capital city, which poses a challenge for the HR directorate which has to distribute newly graduated doctors evenly between the capital and provincial hospitals. It was not possible for researchers to find out which criteria were used to make this decision.

“In the 5th year there would be deployment list from Ministry of Health Head Office, where there were 4 choices which were Harare Hospital, Parirenyatwa Hospital, UBH [United Bulawayo Hospital] and Mpilo Hospital. Most people (80%) would choose Harare and only 20% would choose Bulawayo but it was supposed to be 50-50. This meant that 30% of those who chose Harare were then forced to go and work in Bulawayo. To solve the issue there was a list that would come from the head office

Human Resources Directorate of who would go where.” IDI 02 Male Manager Gvt District 1

After the crisis, there was a severe shortage of health workers as a result of the high attrition due to resignation or abscondment which took place during the crisis. After 2008 improvements in the economic situation and the introduction of the US\$ as official currency attracted many of these workers back to the public health system.

“Sure, first of all we found that we had a lot of reappointments, as soon as they heard that there was this US\$, we had a lot of applications seeking reappointments from the nurses...” IDI 05 Male Manager Gvt District 2

The HSB issued a circular in March 2009 to expedite reappointment of returning health workers without, as otherwise stated in the existing regulations (HSR 2006), having to go through the convoluted process of appointing a disciplinary board to determine whether the health worker could be reappointed.

“Right, when we started to have foreign currency [dollarization] we had a challenge; [members] who had left the Ministry of Health, during that time they were now coming back so there was now need for that circular reappointment of 2009 March which stated that everyone who had left his/her job was now able to come back to work...” IDI 08 Male Manager Gvt District 3

Before the crisis the process would take several months but after this exceptional arrangement it only took around one month to reappoint. The District Health Executives were allowed to constitute reappointment committees which would then review case by case and decide to reappoint. No letter was needed from the HSB although the whole process had to be minuted and communicated to the HSB.

“The great demand to fill vacancies forced the district human resources department to quickly deal with the applications for reappointment. Due to the fact that we were in great need of staff we would do it very fast, like say we receive a letter this week the following week we would sit down as the board and write our minutes. Within 3 weeks the province would be made aware of it and they would take maybe a week to respond, so within a month a person would start work...” IDI 08 Male HR Manager Gvt District 3

The new procedure for reappointment involved submitting an application to the last station they served at. The DMO would appoint a committee made up of the Head of Department where the returning health worker last served, a representative of each of the departments of the station, the District Nursing Officer and the HR department. The applicant was assessed by the committee which would make recommendations whether to reappoint or not. From the evidence presented by the candidate, the committee is constituted specifically to review applications by returning health workers. The reappointment also has to be approved at the various administrative levels. After the meeting of the reappointment committee, the minutes of the proceedings and the application for appointment were submitted through the normal channel. Most returning health workers were interviewed and reappointment was immediately recommended provided they had no criminal records.

“Usually when a person applies for a job [to be reappointed] at our station we go to the HOD of that department where the person used to work before resigning or absconding, we discuss with them the DMO is the one who will appoint the committee. People from the HR will be writing minutes and giving advice so we look for senior members especially from the department, like say the person is a nurse we take the matron or sister in charge, from the DNO’s office we also take one person from the EHT department we also take one person, so we take people from different departments but the one from the particular department will have full knowledge about that person so that person from the particular department must be available from the department..., after the assessment the committee will recommend for the reappointment of that person or for no reappointment.” IDI 08 Male HR Manager Gvt District 3

“Okay, when I came back from South Africa I stayed at home and then I heard from a friend that the government was taking back nurses who had left due to economic issues, so I had to reapply. I applied at [District 2] and xxx Hospital. xxx Hospital responded to my application and they invited me for an interview but they said I should go through the Provincial Medical Director’s Office. I went to see the PMD and he said I can go to xxx Hospital and get an interview date. I came here for an interview and I was given the post as an RGN.” JH 40 Female Midwife Gvt District 2

However, despite economic recovery, the introduction of a recruitment freeze in 2010 as a measure to address the overinflated Civil Service for which management the government

lacked fiscal capacity, represented a major barrier to reappoint returning workers. For any person to be employed in the health sector, the health ministry through the HSB, had to get the permission from the Ministry of Finance (MoF) for a particular vacant post to be filled. This increased the timeframe of the posting process (Dieleman et al 2012).

“...the unfortunate thing is whilst our economy is recovering it has not recovered fast enough to absorb those who wanted to come back, back into the system, so the news goes back to those who are still there and sort of saying let us observe from afar and see how this thing works out and they hear their colleagues who had come who are still not back in employment. So, some are still out wanting to come back but they are aware the system may not absorb all of them. So, some came back and they were lucky to be taken back into the system but not as many as we lost.” KII 04 Female Manager Health Professions Association National

The implementation of the appointment process changed as a result of the recruitment freeze. Newly graduates are requested to register at HSB after completing their studies. When posts become available because MoF gives concurrence to requested positions to be opened as it happened in 2012 and 2013, the HSB will invite newly graduated health workers who are registered to report to the provinces. The provinces will have received lists indicating where the health workers should be deployed compiled by the HSB. These restrictions all affected new graduates who had to wait until the recruitment freeze is lifted which could trigger attrition if other opportunities become available.

“When we have people who qualify we wait for the unfreezing of posts. The HR [human resource department in HSB] will allocate the posts to the provinces and provinces allocate to the districts. We wait for treasury concurrence.” KII 03 Male Manager Gvt National

3.2.1.4 Implementation of recruitment policies in the FBOs

Recruitment of students applying to schools run by the FBO was mediated by the church authorities but following entry criteria and standards of quality established by the HSB/MoHCC.

“...so the recruitment will always be determined by the training schools working with the nursing directorate. So, that’s the whole training recruitment is done nationally, we [FBO] don’t have anything to do with it as Mission hospitals [although the FBO has training schools for nurses].” KII 05 Female Manager FBO National

Implementation of the PSRs 2000/HSRs 2006 in the FBO sector was inconsistent with appointment procedures being applied differently in different FBOs. Some managers reported having two different processes for recruiting new workers: one which is triggered by the FBO and another one which follow the same procedures as in the HSB sector.

“When we are recruiting [FBO own process] we advertise the posts, and then people apply. We then do the short listing and we respond to those we would have short listed. We invite them to come for an interview then we do the interviewing as a panel. Then they go back and we will then respond to inform them if they were successful or not. If they are successful we call them to come to work. When they are sent by the DNO [normal HSB process] we just accept them. We sit down with them and do a bit of an interview but not as we do with those we recruit on our own because there is no option to say we want you or we don't because the person would have been already sent to us. We then ask them to fill the assumption of duty forms and other forms which are needed.” IDI 07 Female manager FBO District 3

Another manager at FBO facility explained that she gets the list of people to appoint from the District offices and they check whether all the necessary documents are in order as required by the HSRs 2006 in (8) (a, b c, d i-iv). In addition, the candidate will be interviewed by the FBO facility managers and asked about her willingness to work with the religious authority and if she agrees she sign her contract.

“First and foremost we [FBO] get the recommendation from the district and we will then see to if the person intending to come here has all the necessary documents which are needed for the job which he/she wants. After that, there is only a short interview [to see] if that person wishes to work in the mission sector with the Roman Catholic responsible authority. If the responsible authority agrees then the appointment forms and assumption of duty forms are filled in and submitted to the province”. IDI 10 Male Manager Gvt District 3

The FBO health services employ both secular and ordained health workers. There are some variations in their recruitment processes. For the pool of soon-to-graduate secular trainees, recruitment complies with the PSR 2000 and HSR 2006 rules. The students are not recruited specifically into the FBO at this stage, although it is reported that the FBO training school may retain some newly graduated health workers as far as they have vacancies to fill and always with approval from the HSB.

“The Ministry is the one which is.....because we are training for national absorption, so then the Ministry will then say, so many will go there, maybe go to Nkayi or wherever and then a few will remain with the training institutions if they have the vacancy” KII 05 Female Manager FBO National

“At school when the students are about to finish [their training], each student writes down the province where he/she wants to go and then the PNO will deploy them, he/she is the one who allocates them to districts like say, you go to [District 1] and go see the DNO then the DNO will deploy them to us but [the Training school] can just say we need three here [at St Theresa] and they can even mention names preferably so and so and they can be given to us.” IDI 03 Female Manager FBO District 1

The health workers that were selected to remain at the FBO facility after pre-service training were not aware of the criteria applied. Some health workers speculated that being a Catholic, participating in church activities and general good behaviour were important in putting one in a favourable position to be selected to remain. Some of them suggested that workers were asked whether they wanted to remain or not and some report that the FBO just selected those that it wanted to remain.

“...I think the main reason why I was selected to remain behind is that it is a mission hospital and I am a catholic so I used to participate in church activities like conducting Mass with patients, singing and doing lessons with patients every Tuesday, Thursday and Friday.” JH 01 Female Midwife Gvt District 1

“...all the matrons [when the cadre completed training in 1989] were white people and were Dominican sisters I don't know what they were considering for them to select us, maybe it was good behaviour.” 34 Female Midwife Gvt District 2

Newly graduated secular health workers who are not willing to remain after having been asked to or had not been selected to remain at the facility after pre-service training were released and have to apply for jobs at other facilities.

“In 1994 after the training I was selected to remain behind and work as a State Certified nurse and others were released to look for vacancies somewhere else. We

were 24 all in all but only 4, me included, were selected to remain behind.” JH 01 Female Midwife Gvt District 1

“I was deployed in 1995 at St Theresa and I worked there as RGN/SCMN... Initially from what we know it is part of the administration procedures here that after receiving the results if they have any posts at the hospital they would choose among the people who would have qualified.” JH 13 Female Midwife FBO District 1

“We were just called to the office and we were told that we have been selected to remain.” JH 34 Female Midwife Gvt District 2

Recruitment of ordained workers during the pre-crisis was managed by the missions. After completion of pre-service training they would all work in FBO health facilities. Ordained participants reported that they completed their noviciate (period of training/induction for nuns) before recruitment into nursing school.

“I joined sisterhood in 1978. [I went for nurse training] I...think it was from 1991 to 1992. I was at St Annes Brunapeg. Uhhh it should be 1990, it was just a year programme...” JH 57 Female Midwife FBO District 3

“I am 58 years old and I did forms 1 to 4 at Mukaro Mission School and it was from 1968 to 1971. In the same year in 1971, I joined sisterhood [Nun] and trained at Driefontain Mission Hospital. I later trained as an SCN at Silveira Mission Hospital from 1973 to 1976.” JH 36 Female Midwife FBO District 2

“... In 1977 I went to train as a sister but I did not just start as a sister I started as a postulant, that is candidacy. I was in Harare at St John’s Roman Catholic Church under the Dominican sisters. That year 1977 I went back to school to do Form 3 and Form 4 under the same Dominican sisters and I finished in 1979. ... After the Noviciate in 1983 I started registered general nurse training at Parirenyatwa hospital in Harare up to 1985. After the training, I was deployed at Silveira Mission hospital in Bikita in 1986 and I worked there up to 1989.” JH 18 Female Midwife Gvt District 2

After the centralisation, ordained health workers were managed by the same system that manages all health workers, as prescribed by the HSRs 2006/PSRs 2000. Health administrators at the FBO and ordained health workers reported that although there was a

section in the FBO responsible for management of recruitment of ordained staff, these had to go through the HSB recruitment process after pre-service training. However, there are some differences such as ordained workers always being posted to FBO facilities.

3.2.2 Bonding

Bonding refers to the period of compulsory service that government sponsored newly graduates agree to serve after completing their education (either pre-service or post-graduate). Bonding is broadly used to retain workers in less attractive areas (e.g. rural) and it is usually supported by legal frameworks that justify why it is being implemented and for how long the workers will be bonded. The formal agreement (contract) forces health workers to remain in service in a specific position, level of health services or in country upon graduation to compensate for the government's investment in their education. Alternatively, they can pay a fine that covers some or all the cost of their training (Labonte et al 2006). Bonding of HRH has been recognised as one means of retaining health workers in post although there is limited evidence about its effectiveness and in some instances, has showed perverse effects on health workers' performance and turnover (Murphy et al 2016, Namakula et al. 2016, Dussault et al 2006, WHO 2006, WHO 2010).

3.2.2.1 The bonding Policy

In Zimbabwe bonding was first suggested in the "Health for All Action Plan" (1986) which called for the MOHCW to establish bonding arrangements. In an attempt to make bonding more effective, the MoHCW amended the Medical Dental and Allied Professions Act in 1987 to provide a contract for bonding of medical graduates. The Human Resources for Health Strategic Plan of 2010 acknowledges that what was used as the guidelines for pre-service training bonding were arrangements between the MOHCC and professional associations (MoHCW& HSB, 2010, Chikanda, 2010, Mutizwa-Mangiza, 1998 The 1987 bonding policy, as reflected in the Health for All Action Plan 1986, stipulated that newly graduated or qualified health workers to serve in the public sector for a period equivalent to the period of training. In the PSRs (2000) and HSRs (2006) there is no specific paragraph for bonding for health workers after pre-service training. Bonding was self-regulatory through the professional associations. The Bonding policy for nurses introduced in 1997 states that all nurses completing training were to be bonded for a period equivalent to the period of training. That is, nurses completing initial basic general nurse training were bonded for three years (MoHCW & HSB 2010 b) or medical graduates for seven, two of which were to be spent at rural stations

(Mutizwa-Mangiza, 1998). However, recent studies suggest that doctors working in district hospitals are only bonded for one year (Dieleman et al. 2012).

3.2.2.2 Bonding policy Change

The pre-service bonding policy has had a lot of controversy because it has not been provided for in the general employment regulations. Bonding has been implemented since the 1980s with mixed results prompting several changes during the crisis period. In 2007 bonding for nurses was revised to include the withholding of certificates and diplomas of newly qualified nurses until they completed the bonding period. (MoHCW & HSB 2010b). The MoHCW and professional councils, in an effort to stem the tendency of members leaving the health service soon after training, made arrangements whereby health workers were expected to serve Government for a minimum number of years equivalent to the duration of the training (MoHCW & HSB 2010a). In 2010 with the recruitment freeze government relaxed the implementation of the “withholding of certificates policy” so health workers now receive their certificates immediately after qualifying. In addition, the freeze has also meant that bonding has been overtaken by events and since health workers were no longer guaranteed a job on graduation, they could immediately seek employment in the private sector.

Bonding applies also to health workers going for post-graduate training. Subject to sub section (4), of the HSRs 2006 “manpower development leave”, or study leave, may be granted by the board or a delegated authority to any member who (ii) if required to be bonded in terms of subsection (8) agrees to be so bonded and signs the bonding agreement before going on such leave. Any member who goes on study leave whether continuously or on a part-time basis, for a period exceeding three months shall be bonded for a period equal to the period of study leave.

3.2.2.3 Implementation of the bonding policy in the Public/HSB sector.

Bonding was introduced in 1983 (Sanders, 1990) as a response to the high attrition of health workers from the public to the private sector (Loewenson et al 1991). However, evidence from informants, shows that the implementation was very unsystematic and inconsistent. Health workers were bonded for the period equivalent to the number of years they would have trained.

“...anyone who goes to study any programme will be bonded, the number of years that the person would have spent training will be the same number of years that they will be bonded” IDI 09 Male Manager Gvt District 3

Prior to the crisis bonding, in addition to its retention effects, was also used as an induction period to assess if cadres were able to put to use what they would have learnt at school and that it completed the cadres training to become a fully skilled and fit for practice cadre.

“Long back it was there to retain nurses as the nurses are trained using public funds. It also used to make sure that the nurse will be moulded through the supervision by the senior [staff] during the bonding period.” KII 02 Female Manager Gvt Provincial

“Bonding certainly assisted in retaining (health workers).” KII 01 Male Manager Gvt Provincial

“I think bonding is a period of observing whether a nurse can use the knowledge they would have acquired in school. It is also a period to gain experience and give confidence to the cadre. I can say it’s a way of assessment. [...] Personally, I think that bonding is good from the point of view that it is a benefit or a way of assessment.” HSB IDI 01 Male Manager Gvt District 1

“As a manager the issue of bonding is important because you will have empowered that individual because there is a lot in teaching especially the orientation and induction, it takes time for a nurse to get empowered to be able to work and articulate as a nurse for example from a student nurse to an experienced nurse and then after all that someone just resign and go, oh no, at least serve for some time.” IDI 06 Female Manager Gvt District 2

As the country went into recession from 1997 to 2009 and health workers began to migrate to other employers/sectors seeking ‘greener pastures’, the policy became difficult to implement. The bonding period was reduced in 2005 at least for some cadres as this nurse reported.

“By right MoH states that you are supposed to serve three years in the Ministry after basic training but it was later reduced to two in 2005 after a circular.” IDI 06 Female Manager Gvt District 2

At the peak of the economic crisis staff turnover increased substantially as health workers were leaving or absconding without fulfilling their bonding contracts and the opportunity cost of fulfilling the bonding period was higher than the option of employment outside the country. As a reaction, the government in 2007 revised the policy to include withholding of certificates and diplomas of newly qualified cadres until they fulfilled their bond.

"When we finished school we did not get our diplomas; we were asked to serve in the government for three years. I think it was bonding. I decided to go back and work in the government because I wanted to get my diploma." JH 26 Female Midwife Gvt District 2

"The nurses were bonded for a period equivalent to the training period and you would not get certificates for the three years you are bonded." KII 02 Female Manager Gvt Provincial

"...it helps the government but it doesn't benefit us, because even if you find somewhere where you would like to go that was not possible because you were bonded. Maybe you would go there after bonding but usually after your bonding that opportunity might not be still available." JH 08 Male EHP Gvt District 1

During the crisis the implementation of the bonding policy had some challenges to its legality, especially the withholding of certificates until one fulfils their bonding contract, was questioned by some health workers. They felt that not everyone was consulted before the policy was put in place and some managers felt that the policy was coercive and ineffective in the long term.

"Personally I think that bonding is one policy that was not well consulted because forcing someone to stay somewhere he does not want will not do them any good... [] ...Bonding certainly assisted in retaining but I don't know whether it is legal... [] ...there is no written down policy that states that certificates for nurses or doctors should be withheld until they work for three years. We wonder why they are bonded... [] ...After a period of three years when they finish the bonding they may still decide to leave" KII 01 Male Manager Gvt Provincial

However, bonding was acceptable to some health workers as they felt that it was a way of giving back to the government for the educational support received as this nurse reported:

"In fact, I think it [bonding] was good because if you have been given something you have to work for it appreciating it." JH 04 Male Nurse Gvt District 1

At the end of the crisis, when retention incentives were introduced to help reduce staff turnover, some managers felt that the bonding policy became redundant as retention

incentives were producing the same effect originally intended by the bonding policy and also it wasn't very strategic as workers wanting to leave would still do it once the bonding period was completed.

"Since the introduction of incentives health workers now want to go to work anywhere, so bonding should be removed." KII 01 Male Manager Gvt Provincial

The freezing of posts in 2010 and its subsequent limitations for newly graduates to find their first job saw the government revising the policy of withholding certificates and they started to give the new graduates their certificates soon after qualifying so that they could look for employment elsewhere.

"At the moment because of the shortage of vacancies and the freezing of posts, the nurses are now being given their certificates immediately after qualifying." KII 02 Female Manager Gvt Provincial

Regarding post-basic training, cadres acknowledged that bonding forms would be completed before going for training so that cadres are aware that they have to go back to their stations. In District 2 some managers and cadres were aware that cadres had to fill in bonding forms before they go for post basic courses.

"...The same [bonding policy] applies to post basic courses; if the course is one year long, then after the course you are supposed to go back to your station and serve for one year before you decide to go and work anywhere else." KII 04 Female Manager Health Professions Association National

"...we even complete the bonding forms so they will be aware that when they go they are supposed to come back and serve the institution – IDI 05 Male Manager Gvt District 2

"Before I went for upgrading I signed a contract with the government of Zimbabwe through the human resources that when you qualify you will come back and work for the same duration that you would have trained, if you have trained for one year you had to sign a contract to say after completing the training I will come back and work for the government of Zimbabwe for that one year that I trained." JH 27 Male Nurse Gvt District 2

In the HSB sector managers and cadres had an understanding that after undergoing post basic training graduates return to the facility where they were working and usually they have to serve for the same period of training before they transfer. There were some participants that reported having to serve for at least one year but that may have been the period covered by their training. Managers also mentioned that this is clearly explained to cadres before they go for training. This is to ensure that the institution that sent them for training, benefits and that they provide the services that their training equipped them for. The cadres who get opportunities to do post basic training get it on the understanding that the facility needs that cadre with those skills and therefore the cadre should provide the services to fulfil the justification used to confer them the training opportunity.

“..... We have the bonding which we advise them before they go that you have been trained or you are going for training so that the institution benefits and the Ministry of Health as well. So normally we say if someone goes for training, let that someone come and serve the institution for at least one year before that cadre thinks of transferring. It’s a recommendation we have always taken that whenever someone goes for training, let the institution benefit, let the Ministry of Health itself benefit to the extent that we even complete the bonding forms so they will be aware that when they go they are supposed to come back and serve the institution” IDI 05 Male Manager Gvt District 2

“On the government side you go back and do bonding for one year... Yes, in the same district and the same clinic where you would have been working so that they see if there are improvements from what you have been doing before training and after training”. JH 55 Female Midwife Gvt District 3

“It is good in the sense that you would have been sent by the facility so you have to render back the service, if you think of going somewhere it would not be fair that after training you will just go without rendering the service.” JH 55 Female Midwife Gvt District 3

Bonding after post basic training was seen by some cadres as a way of giving back to the institution that would have sent them for training.

"To me it was fair because we are saying; the reason why we are training is because there is a knowledge gap, if are not a midwifery for instance, now we are saying let’s fill that gap so that we have the knowledge and you just can’t walk away just because

you have a better qualification that markets you. So it's fair that you also serve the community that brought you up, because normally if people train, the next thing is that they would join the city councils as they usual advertise for the posts in the newspapers and the next thing you are gone and you wouldn't have served the community that gave you that knowledge, so to me it's fair. "JH 27 Male Nurse Gvt District 2

"The fact that you are funded by the government to do the post basic and one will be getting pay, you must serve for some time. You fill in forms that stipulate that you will work for government for a certain period of time for at least one year; if you want to leave the government you can do so after the one-year bond. The certificates will be kept by the government until you finish the bond" JH 19 Female Nurse Gvt District 2

"It is good in the sense that you would have been sent by the facility so you have to render back the service, if you think of going somewhere it would not be fair that after training you will just go without rendering the service." JH 55 Female Midwife Gvt District 3

Though some health workers appreciated bonding, some cadres expressed unhappiness with the bonding policy because it separates them from their families who are only allowed to move after the bonding period.

"Also the issue of bonding is not fair because after my midwifery training I cannot go and live with my spouse until I serve at the hospital for a year which is not safe especially in this era of HIV and AIDS" JH 26 Female Midwife Gvt District 2

3.2.2.4 Implementation of the bonding policy in the FBO sector

Following the formation of the HSB all health workers in the health service had to be administered by the HSR 2006. This meant that the FBO is governed by the very same bonding policies applicable to the HSB after pre-service or post-graduate training. Ordained staff reported bonding being irrelevant to them as they are at the disposition of church authorities.

"Like after the training we used to know that a person will be bonded for a year before he/she can say I no longer want to be here, but for us sisters that rule doesn't apply, we stay at a place until we are told to move." JH 18 Female Midwife Gvt District 2

3.2.3 Transfer

Transfer is the process of moving health workers from one post to another. Transfer is normally used by management to strike a balance between available HRH and distribution of available critical skills, but it may often be triggered by the employee's preferences. This HR function takes on additional importance in crisis situations when workers may change their preferences due to security or other reasons related to the conflict which, in turn, often leads to shortages and maldistribution of skills according to health service needs.

3.2.3.1 Transfer policies

Before 2006 transfer of civil servants was regulated through section 13 of the Public Service Regulations 2000 (PSR 2000). The policy reflects the compulsory nature of transfer (e.g. *"a member may at any time without his consent be transferred by the Commission or a delegated authority from the post which he occupies to any other post in the Public Service whether the post is inside or outside Zimbabwe"*). Workers can be transferred permanently or temporarily not exceeding a period of three years. Refusal to obey an instruction of transfer is treated as an act of misconduct. However, the regulations say that transfer should be planned to minimise discomfort on the part of the member concerned and his family and be notified timeously to the member who should be provided with all necessary information relating to the transfer. Transfers cannot be used as a punitive measure except in cases of disciplinary procedures.

3.2.3.2 Transfer policy changes

The major change which has implications for the transfer of health workers is that the implementing authority, the PSC, was replaced by the HSB in 2006 and that the PSR 2000 was replaced in the health sector by the Health Service Regulations 2006 (HSR 2006). The HSR 2006 introduced some changes to the PSR 2000 regulation of transfers: 1) the length of a temporary posting has changed from not more than 3 years to *"for such a period as the Board may determine"*; and 2) the addition of the opportunity for a health worker to make a representation about an intended transfer.

3.2.3.3 Implementation of transfer policies in the Public sector/HSB

Job histories with older health workers show that before independence they were very mobile with some participants reporting that, particularly at the beginning of their professional careers, they accepted appointments even for a few months to replace others who were on leave.

“Early 1974 I came back [after preservice training] to work at Mvuma hospital [government]. My title was Medical Assistant; we were not yet called as SCN then. I worked for 2 months here and in 1975 applied and went to Harare hospital [Government] and I was there for 4 months. In 1976 I applied and went to Bhasera hospital and I worked there for 3 months. From 1977 up to 1978 I was at Lalapansi clinic [RDC]. I then moved to Chenjiri rural health centre [RDC] in 1979. That same year I went to Nharira hospital. I then moved from Nharira [in 1979] coming to Mvuma hospital...” JH 09 Female Nurse Gvt District 1

In the pre-crisis period workers' needs and preferences were considered. Particularly family reunification was often mentioned as a reason to request transfer.

“My husband works in environmental health so he was transferred to Jeka in 1990. Bonda was far from Jeka hospital so I transferred because I wanted to be together with my husband.” JH 60 Female Nurse Gvt District 3

“...it was because of my husband. Since I was now married to him he wanted us to transfer. He wanted to join the government because Regina Coeli was a Mission Hospital so he just wanted to go to Kotwa because it was a government Hospital and it was near his home area because he was from Chiendambuya We applied and got the job... both of us in 2001 and had to resign from the mission hospital.” JH 40 Female Midwife Gvt District 2

Mobility between sectors in that period was quite easy with workers referring having moved from government to RDC and to FBOs. Some of them referred having moved out of the public sector for some periods.

“In 1990 I enrolled at Morgenster Mission Hospital to train as a State Certified Nurse up to 1992. In 1993 I came to District 2 and worked under Zimbabwe Rural District Council. Under ZRDC I worked at various clinics which include Jackson clinic from

1993 to 1994; Malisa Josepha in 1995; Simana clinic 1996 and in 1998 I went back to Malisa Josepha. Late 1998 I resigned from ZRDC and I joined Sable Chemicals and I was still working as an SCN and I worked there up to 2000. Late 2000 I left Sable chemicals and I joined the government of Zimbabwe and that is when I came to Nyoni rural health centre.” JH 27 Male Nurse Gvt District 2

The high attrition during the pre-crisis and crisis periods pushed managers to become stricter in approving transfers. As replacement of transferred cadres was becoming increasingly difficult, managers requested health workers to arrange swaps with other colleagues looking for transfers ('lateral transfers') to ensure that no vacancy would be created when a transfer occurred. Swaps were organized either directly with the colleague wanting to move or through the managers.

“...as an HOD I just realize that if someone moves away there will be less nurses here so I might refuse the person to move to another facility. So, I might say, no if you want to move to another place first find someone who you can swop with because I know that if I lose you I will be in a crisis...” IDI 08 Male Manager Gvt District 3

“I then moved from Nharira coming to Mvuma hospital, so I exchanged with another nurse. My husband was here in Mvuma and her husband was in Chivhu so we did a cross transfer.” JH 09 Female Nurse Gvt District 1

“... when I tried to talk to the DNO that I want to go to Masvingo I was told that I should seek for a lateral transfer. I should convince somebody who is at a facility where I want to go so that he will come here and I will go there.” JH 03 Male Nurse Gvt District 1

“I went to the PNO's office and requested for a swop or to be deployed this side. I was told that I had to wait until there were vacancies here at Silobela Hospital. They said they would contact me...” JH 24 Female Nurse Gvt District 2

During the crisis the HSB informants pointed out that vacancies were high across the board, but the rural areas had higher vacancy rates than facilities in urban settings. The problem became so acute that in some areas health services were suspended due to shortage of health workers. The crisis years saw an upsurge of health workers applying for transfer for personal reasons.

"People were transferring like hot buns both in Banket and Silobela" IDI 06 Female Manager Gvt District 2

It was difficult during that time to deny health workers to transfer as otherwise they were prepared to leave the country and do any other job and hence pragmatism demanded that managers become flexible.

"Transfers were easy during the crisis because there were more vacancies than health workers seeking those posts. One had to be reasonable; it was either you let the cadre transfer to a preferred post or the system will lose the cadre altogether." IDI 02 Male manager FBO district 1

"In 2006 ...I went to work at Chinhoyi Municipality Clinic until 2007. In 2007 things were not well here in Zimbabwe so I decided to leave the country and I went to Swaziland and I worked part time for about six months. It was difficult to get a job in Swaziland so I decided to go South Africa and was there for about nine months." JH 22 Female Midwife Gvt District 2

During the crisis, it was possible for health workers to change decisions even after the transfer process had commenced. Some health workers reported having been able to reverse the process after making an assessment of the new facility that they were transferring to.

"I wrote a transfer letter and my papers were processed and when I was about to go I went to the place where I wanted to go and the environment was not just favourable for me so I just cancelled the transfer" JH 46 Female Nurse Gvt District 3

Documentary evidence on the current process of transfers initiated by health workers was not available to the researchers but this verbal account from a HR officer at district level explains the process.

"Normally people come to the HR stating that I want to transfer, I want to join my family which is in another district, we then tell the person how to write the transfer letter, then after writing the letter the person will take the letter to the HOD [Head of Department] where she would be currently working. The HOD will write a confidential report which is not seen by that person who wants to transfer. This letter will state the time the HOD would have worked with that person and the way that person works."

After the HOD had finished they will bring the letter to the HR department, the person who wants to transfer will not know what will be happening everything will be in our hands. We then write and address our letter to the PMD stating that we have our member who wants to go to, for example to Shurugwi hospital, the DNO and the matron do not have any objection so as long as there is a vacant post where the person wants to go, so may you confirm with us if there is a vacant post where the person wants to go. The province will also write their letter and send it to Shurugwi. They will send another copy this side showing that they have seen the letter. If they get a reply they will send us a letter back and the other copies will be send to the Permanent Secretary stating that there is a person who is being transferred to Shurugwi so we seek for your authority for the person to go all the districts did not object, so after the letter had been approved the person will be able to go. The matron from this side will write a letter stating when she will be able to release the person after looking at their duty roster. But if it is within the district it will not take long because the places are close by, but if the person is moving into another province or district automatically it has to get an approval from the Permanent Secretary.” IDI 04 Male Manager Gvt District 1

3.2.3.4 Implementation of transfer policies in the FBOs

The rules on transfer applicable to secular health workers working at FBO facilities are the same rules as outlined in the PSRs 2000 and HSR 2006. In principle, the health workers go through the same process as outlined above. The process starts at facility level and heads of departments (DNOs, Matrons, DEHOs, SICs) are responsible for the initial compilation of the application. It is important to note that departmental heads have to provide a covering letter which is attached to the applicant’s letter before sending the application to HR or district.

“...when I wanted to move to Zvishavane, I spoke to the DNO and the DNO instructed me to get a transfer letter here [St Theresa], I sent my letter to the matron so that she will attach her letter and send to the DNO.” JH 12 Female Midwife FBO District 1

Managers at FBO institutions reported that staff working under them could be transferred to any preferred post in the health service if they applied through the normal channels. The official position from the managers’ perspective was that transferring was easy upon fulfilling the necessary formal applications.

“Well with regards to transfers it is the will of the cadre who will be in need of a transfer and this will be in conjunction with the district hospital and district executive” IDI 10 Male Manager Gvt District 3

“Health workers whether Mission or Government employees can transfer but the transfer is easy.” KII 05 Female Manager FBO National

The foregoing assertions by FBO managers contrast markedly with what secular health workers say about the process of transfers. During the pre-crisis period these health workers reported that it was difficult to get a transfer, particularly when the reasons for transfer were about the way they were treated by the institution. Health workers were both afraid to make the transfer request but also lacked sufficient information on the procedure for making the request. Requests from health workers seeking transfer were reviewed by the church authorities and health workers were not very comfortable revealing the reasons why they wanted to transfer. Among the health workers interviewed none had transferred smoothly from the FBO to the HSB. Some had to resign and then got appointed into the HSB.

“I wrote a resignation letter [in 1995] to the matron [FBOHospital] and she did not want me to transfer but I persisted with the issue giving them my reasons why I needed to transfer. However, it was not easy to tell them that I was not happy with the treatment I was getting from them; St Theresa is run by Dominican sisters those who put on black head gear so I did not tell them about that I just told them about my marriage.” JH 01 Female Midwife Gvt District 1

“...there was a time [between 2009 and 2014] when I wanted to transfer but I failed...I think it [failed] because of shortage of staff...Ahh you will not succeed, what you do is that you just submit your papers [indicating] that I want to transfer but the papers will go nowhere. At one time, I tried it submitting the transfer [application] when I wanted to move to Zvishavane, I spoke to the DNO and the DNO instructed me to get a transfer letter here [St Theresa], I sent my letter to the matron so that she will attach her letter and send to the DNO. The things did not move for about 2 months. I made a follow up but I was told that my papers were not posted to the district.” JH 12 Female Midwife FBO District 1

Health workers report that matrons in the FBO sector would refuse to grant them permission to transfer. The reasons for not approving transfers, according to managers was that they did

not want to lose hard-working cadres and, as it happened in the government sector, that letting health workers transfer would leave vacancies that were difficult to fill, particularly after the recruitment freeze was introduced.

"[Interviewer] Ok, are there any situations where the Catholic can say you can't transfer this person? [Interviewee] Yes, it's normal [for the FBO to say you can't transfer this person because] ...Maybe that person will be a hardworking cadre so they would not want to lose the cadre." IDI 10 Male Manager Gvt District 3

"Our DNO had said that we could not transfer because there were very few nurses and it was difficult to fill in posts if people transferred." JH 63 Female Nurse FBO District 3

Besides barriers from FBO authorities, district managers also discouraged health workers seeking to be transferred telling them that the process was long and that it may put at risk receiving their salaries during the process.

"The other problem I heard was that if you transfer from mission to the government sector the processing of papers would take long to be reappointed and that meant no salary for a long time and so I was a bit hesitant." JH 63 Female Nurse FBO District 3

Transfer of ordained staff, while decided by church authorities according to the needs of the health facilities they managed, is done in consultation with the HSB and in most instances the transfer is from an FBO facility to another FBO facility which might be in a different district or a different province.

"Ok, for me [a nun] there was no choice. As missions, we have hospitals; they [church authorities] transfer you where there is need and then processing of papers will be done by the people who work in the administration department...For us there is no choice, as missions we work within the mission environment." JH 57 Female Midwife FBO District 3

"There were some regulations that I used to know about posting but then for us sisters the rules did not apply. ... for us sisters that rule doesn't apply, we stay at a place until we are told to move." JH 18 Female Midwife Gvt District 2

Once decisions to transfer ordained workers is made by the church authorities, facility managers communicate with the district office to formalise the transfer process.

“...the person is a Dominican sister so their authorities [Dominican hierarchy] are the ones who authorize them to transfer... [] ...No, their authorities are the ones who are responsible, they make changes. I’m sure towards the end of every year they rotate the sisters. However, they will just do the same process that other employees go through, so it would be an attachment coming from their region stating that they are the ones who have made that particular person transfer.” IDI 03 Female manager District 1.

It was not made clear to the researchers how that communication was done and verification of this process was difficult as personnel files for the FBO facilities are sometimes not available at the district medical offices.

“You have reminded me of something that is outstanding; am not sure but I think [the files for Mission hospitals] are still with the Mission hospitals.” KII 01 Male Manager Gvt Provincial

Some of the FBO ordained health workers reported having been transferred very frequently, even on the same year.

“In 2003 I went to FBO and that same year 2003 I was transferred to Matibi mission hospital up to September 2004. In 2005 I was transferred to FBO mission hospital and I worked up to 2008. From 2010 to 2012 I was at Muonde Mission hospital. And in that same year 2012 I was transferred to Silveira Mission hospital. In 2013 I was transferred back to Holy Cross and I am still working here at Holy Cross [2014].” JH 11 Female Midwife FBO District 1

In some instances, FBO authorities transfer ordained staff on rotational basis.

“No, their [religious] authorities are the ones who are responsible; they make changes, I’m sure towards the end of every year they rotate the sisters [Nuns]. However, they will just do the same process that other employees go through, so it would be an attachment coming from their region stating that they are the ones who have made that particular person transfer.” ID03 Female manager FBO District 2

3.2.4 Secondment

Secondment refers to the temporary transfer of workers to another post for a limited period for a specific reason.

3.2.4.1 Secondment policies

The PSRs (2000) states that a worker may at any time, with his (or her) consent and at the invitation of head of Ministry or the Commission, be seconded by the Commission for a period not exceeding three years to a post in an approved service. Terms and conditions of services for seconded workers should be governed by the contract between the worker and the service concerned. Seconded workers who resign or are discharged due to misconduct or are unfit or incapable of performing efficiently the duties of his post shall be considered as dismissed from the Civil Service unless the Commission reinstates him.

3.2.4.2 Secondment policy changes

The HSRs (2006) revision leaves the period of secondment undefined. Neither does it spell out any underlying rationale upon which a decision for secondment is made. However, it does outline the authority of the body to effect secondment which lies on the HSB.

3.2.4.3 Implementation of secondment regulations in the Public sector/HSB

Decisions about secondment are made at district level. The period of secondment for a health worker to a different position is decided either by DMO or DNO according to local needs.

“(asked about who decides about the period of secondment) ... Ummm because we are looking at ummm a district setup, it’s headed by a District Medical Officer With his technical team, the DHE [District Health Executive] so you will find the DNO [District Nursing Officer] would know what value moving nurse X to health centre Y and for whatever period is going to make within the whole district. The same applies to DEHO [District Environmental Health Officer] he would know if I move this EHT, but it’s mostly ... I think it applies to nurses” KII 07 Female Manager Gvt National

Health workers who were interviewed pointed out that the period of secondment is not clearly communicated to cadres by their managers. This is the case because secondment is normally a local arrangement by managers to make sure that their facilities are operating effectively. It

is considered an emergency measure and hence the process is done hurriedly with the main concern being to have health worker in post as quickly as possible; and often with no related paper work.

“So when they sent me there it was like for a short time but I stayed there for a long time and I only came back here after another nurse transferred from Mapiravana clinic to Chizhou...” JH 01 Female Midwife Gvt District 1

“...For this whole process, no paper work was done; I was just told that you are going to Chizhou Rural health centre ... [] ...They did not write any letter [when she was seconded]” JH 01 Female Midwife Gvt District 1

“In situations where there is a gap or when a need arises e.g. an emergency, we look at health centres with less burden and then pick a nurse to replace the one who will be going on leave or attending to an emergency.” IDI 01 Male Manager Gvt District 1

Secondment has been used in the health sector in different ways during the last decades depending on the problems faced in the workforce. In the crisis period, it was used to alleviate the problem of shortages due to brain drain from public sector to NGOs or abroad. Due to the staff shortages, some health workers were seconded from provincial offices to district offices so as to alleviate the problem

“Even some workers in my office [provincial level] have been pulled from district hospitals. Even workers at Gweru District offices, they are all from Gweru Provincial Hospital.” KII 02 Female Manager Gvt Provincial

“I can give an example of EHTs. More EHTs went and joined NGOs which were operating in our area... [] ...Secondment actually helped the situation. We would second health cadres especially nurses to these areas.” KII 01 Male Manager Gvt Provincial

While secondment is a procedure included in existing regulations, managers recognise that there is problem in communicating secondments to health workers which have a negative impact as they do not have time to do a proper handover to their remaining colleagues.

“...what we are failing to improve on is probably communication so that at least I know if I am being seconded or moved or transferred it is very clear and there are also follow up reports in terms... [] ...if it was for me to pass on skills to others or for me to be supervised am I improving. But it is perfectly normal and provided for within the regulations.” KII 07 Female Manager Gvt National

Secondment of staff does not require a lot of paper work and there may be even no letter written to HR according to some participants. This leaves a sense that the policy is being implemented arbitrarily.

“No there is no paper work [for secondment] because their paper work is here when they start work their paper work will be at the human resources [department] so all the things will be at the human resources department here, so when we second them to the clinics there is no paper work that is done again” IDI 09 Male Manager Gvt District 3

However, in order to maintain the payment of donor-funded allowances to seconded workers, managers need to notify the HR department which then inform the funding partners who need the information for financial management purposes (retention allowances have a logging system for staff which is used to determine whether the cadre was indeed turning up for work).

“Haa normally as long as the person is in the district the DNO just notifies us that we have seconded this person to this clinic even if the DNO does not write a letter. The DNO just notifies us, because we do our returns to the donors [for purposes of payment of retention/HTF] so we would like to know if the person is logging so you will find that the person is now logging at the other clinic which previously she was not logging on, so that is why we want to know” IDI 09 Male Manager Gvt District 3

Secondment is also used as a mechanism to fill vacant posts while waiting for approval from central authorities (e.g. Ministry of Finances) to revise the establishment.

“We second as a temporary measure while waiting for treasury concurrence. In terms of deployment, let’s say a nurse decides to move, we cannot close that clinic, we take nurses from the district hospital or in clinics where there are three nurses and second them. Currently we have 2 clinics that we have seconded people and there is no staff establishment for that. We have three clinics which do not have staff

establishment at the moment but those who are working there are seconded from District 1 Hospital.” IDI 02 Male Manager Gvt District 1

New professionals just appointed to District Hospitals are often seconded to lower level facilities on temporary basis which may have implications in terms of quality of care as less experienced staff is posted in facilities where their supervision is not ensured. In addition, some nurses expressed unhappiness with being seconded soon after qualifying because they didn't get the experience acquired through the induction/mentorship period to which they are normally exposed to by being appointed at district hospitals or similar level facilities after graduation. They also complained about the high workload they get when seconded to lower level facilities which are often understaffed or staffed with less skilled health workers. Colleagues of seconded workers at their original posts also feel overloaded as they have to assume the tasks that the seconded staff is leaving behind. However, others mentioned that this was a good opportunity for them to learn.

“During this secondment period [in 1995 in the pre-crisis period] I was not happy and I was not satisfied at all, there was a lot of work for me. I only had one nurse aide to help me and I was still very young at that time as I was coming from school. However, I gained more experience with work and when I came back here other nurses were surprised because when I was on duty I used not to ask too much but just worked even with no supervision.” JH01 Female Midwife District 1

“The issue of secondment is not really working well because of issues of workload. Once you second a nurse to another clinic it means that the gap they will leave behind will not be filled and this increases workload to those who remain behind. We are still using the same establishment since 2009 for example at Chaka Rural Health Centre (a RHC in the district) the six nurses who are there are from District 1 Hospital, we have left a void at the hospital, it doesn't solve anything. I think posts should be unfrozen and establishments should be reviewed.” IDI 02 IDI 02 Male Manager Gvt District 1

As mentioned above, some health centres were upgraded to hospital status with no corresponding change to the staff establishment. This then generated high demand for services as patients are more likely to present at hospitals than to health centres because the hospital is considered as having more and better skilled staff (besides better equipment and more stock and variety of drugs). Secondment is used to temporarily address this problem.

The upgraded facilities were sometimes lacking key cadres (e.g. midwives) in which case health workers are seconded on rotational basis for initially fix periods (e.g. 3 months). However, after the crisis these periods could be extended and even developed into an indefinite transfer.

“Yeah that is the same thing because if we second, for example in Kana there is a crisis when the establishment was done it was a clinic but it later became a hospital so it is still operating with the establishment of a clinic so we have seen that there is need for us to second midwives because there are no midwives so they go on 3 months basis and its rotational it is now different from the health facilities that it might be indefinite or that someone will stay for longer period than those who do three months” IDI 09 Male Manager Gvt District 3

3.2.4.4 Implementation of the secondment regulations in the FBO

Due to historical reasons FBO institutions do not have allocation of posts for doctors; missions were often staffed through their own networks including volunteer expatriate professionals. Besides the current civil service adjustment policies (e.g. recruitment freeze) and the outdated establishment (e.g. not consistent with current staffing needs) secondment of doctors from district facilities is now bridging this gap; managers reported that secondment is not solving the situation as it generates new gaps in these facilities from where health workers are seconded with the subsequent increased workload for the remaining staff. According to a district manager, government doctors can only be seconded to mission hospitals which do not have posts for doctors.

“My post is at xxx District Hospital [HSB]. When I came into the district, mission hospitals did not have posts for doctors from the government so I was seconded here [FBO hospital].” IDI 02 Male Manager Gvt District 1

FBO managers reported having received seconded staff from the DNO at district hospitals (HSB) without having been given the option to select or recruit them beforehand. Managers then interview these new staff when they arrive for duty to know them better and allocate them to the appropriate post and help them through the administrative processes. A letter is the only documentation indicating the names of the cadres that are seconded to the facility. The letter is written to the head of station receiving the cadres.

"When they are sent [seconded] by the DNO we just accept them. We sit down with them and do a bit of an interview but not as we do with those we recruit on our own because there is no option to say we want you or we don't because the person would have been already sent to us. IDI 07 Female Manager FBO District 2

"Ummh, there is only a formal letter that is written to the sister in charge informing her about the people who will be coming from the district". IDI 11 Female Manager FBO District 3.

Increased workload at FBO services is one reason proffered by health service administrators as justifying the seconding of staff to facilities that are overwhelmed by work.

"Yeah at some point we appreciate secondment because it eases the workload...."
IDI 10 Male Manager FBO District 3

The same reasons were cited by facility managers from all the districts. The DNO is empowered to move staff across facilities of various providers in the district whether they are RDC, mission or government. Managers at FBO facilities would inform the DNO about the staffing situation at their facilities and he or she would second staff across facilities of various providers.

"Normally we lodge our complaints with the district nursing officer so she is aware that we have a great shortage of 4 nursing staff here... since the DNO knows the situation of staff shortage at FBO mission ..." IDI 11 Female Manager FBO District 3
"...we still need more posts at mission hospitals and in response to that we have taken nurses at government clinics to post them to mission hospitals to relieve (secondment); even doctors are also being seconded." KII 02 Female Manager Gvt Provincial

"Right, we have our own establishment as a hospital; if people are deployed to us we have four government clinics. At Nyaje clinic there is a RGN and a PCN which is the full staff establishment allowed at the province and head office. But if the DNO sees that there are challenges at the council [RDC] clinic or mission hospital, the DNO has a right to remove one person from Nyaje clinic to second her to another clinic so that demand for services and staff will be balanced" IDI 08 Male Manager Gvt District 3

The managers in the FBO also reported that secondment of health workers created management problems for the facilities because of the temporary nature of the posting.

“...but what we wish to have at most is to have staff stationed here, those who do not move but work permanently here.” IDI 10 Male Manager Gvt District 3

Vacant posts in the FBOs were filled with health workers seconded on a temporary basis from the district health executive (DHE). Secondment of health workers was viewed as a partial solution to deep seated staffing shortages due to inadequate approved establishments. Nevertheless, it brings a lot of social and economic inconveniences in the lives of cadres affected as some participants indicated that they were incurring more expenses as they need to travel to visit their families at the stations.

“This secondment problem can only be solved by filling in the vacant posts rather than making people go up and down”. JH 48 Female Midwife FBO District 3

“In District 3 we would do other things to complement our salaries but here [where I am currently seconded] there is nothing that we can do actually we now have more expenses e.g. bus fares to go and see my family in [District 3], paying utilities for me here and also for my family in [District 3]”. JH 47 Male Midwife FBO District 3

“I was not happy [with the secondment] it disturbed me because sometimes I should go to Harare and I have to get transport from here to [District 3] and then [District 3] to Harare. JH 48 Female Midwife FBO District 3

There are some incentives for seconded staff that reduce resistance from workers to be moved.

“Usually if a person goes to a certain place for a certain programme they are given T&S [Travel and Subsistence allowances] but just coming without getting anything really does not motivate”. JH 47 Male Midwife FBO District 3

Managers in the FBO institutions receive formal communication when they receive staff that is seconded from the district hospital with their personnel details.

“There is a letter that is written saying that we are giving you these people, they are not yours, they are not in post, like those who are here they have their posts at District

one hospital but they are working here. We do their supervision here but they are employed at the district hospital and seconded here.” JH 11 Female Midwife FBO District 1

The decision to second a staff is made by the DHE but documentation about the process is lacking and some workers reported not having signed any document accepting their secondment; word of mouth was reported as sometimes the only means of communication about the decision to second a HCW.

“Some people had volunteered to come but when that happened I was on leave. When I came back the first group that had volunteered came here and worked for three months and they went back. I don't really know what happened to the second group but they later on said they did not want to come here at Kana. So, we were then asked if we wanted to come and help and we agreed”. JH 48 Female Midwife FBO District 3

“It was our superiors who identified that there was a need for more health workers here at Kana Mission Hospital.... A meeting was held but I was not part of that meeting but after that meeting we were told that some people should go to Kana Mission Hospital.” JH 47 Male Midwife FBO District 3

The managers decide who should be seconded, where and for how long. There are also instances when health workers are asked to volunteer to go for secondment in one district.

“I heard that the first group volunteered but as for our group we did not volunteer we were told to go. We were just told that you are going tomorrow and we were not prepared to go. We could not even give excuses we were just told to go. I remember we did not have food and we were told that food was going to be provided for but when we came here there was no food, so we had to go back and look for food. When we went back it was as if we were being rebellious so they decided to bring us back that same day. We were not given an option. We were just told that if we didn't want to go back then we were going to lose our jobs.” JH 47 Male Midwife FBO District 3

3.2.4.5 Frequency and length of Secondment in government and FBO

Using job history life lines an analysis of the period cadres spent at facilities that they had been seconded to. Seven of the 67 (10.5%) staff interviewed had been seconded during their working life. The average number of times that workers were seconded was one. The longest

that one was seconded to a post was a SCN who was seconded for 15.2 years during the early years of the crisis in 1999 as shown in Table 7. **Error! Reference source not found.** hich is against the 3 years' limit stated in the PSR 2000. However HSR 2006 allowed for exceptions in this regard leaving it to the judgment of managers.

Table 7: Frequency and average length of Secondment in government and FBO

Cadre	Number of Secondments	Maximum secondment period (Years)	Period of appointment
SCN	1	2	Pre-crisis
PCN	2	5	Crisis
SCN	2	15.2	Pre-crisis
RGN	1	0.1	Post-crisis
RGN	1	0.1	Post-crisis
RGN	1	3.7	Post-crisis
PCN	1	5	Post-crisis

4. Discussion

This research project was conceived as part of a wider effort to understand how decisions made or not made during crisis affected health systems and for this particular study the focus was on: how deployment systems between two large organisations compare; how these changed or did not change during the crisis; the stimulus for the change; and how change affected the provision of services. From this study, we aimed to derive lessons that would help to improve deployment to increase equitable access to health services in Zimbabwe and to derive more general lessons on improving deployment policy in other post-crisis contexts. We begin by discussing the limitations of the study. We then discuss the wider context within which deployment was carried out over the study period and then the corresponding policy and implementation responses, and – to the extent that the findings support – the impact on staffing in rural areas. Implications for current and future rural health workforce in Zimbabwe as well as lessons for other countries emerging from crisis are identified.

4.1 Limitations of the study

The study had set out to examine the way in which two different organisations had attempted to address policy and practice of deployment during and following the crisis. During the research, it became clear that as a result of the Health Services Act (2004), health workers in both government and large FBO facilities were governed by the same human resource management regulations. It was therefore not possible to make clear comparisons between the two types of service providers. However, the selection of these two organisations did provide some useful insight into the ways in which FBOs interpreted and implemented the regulations and provided an overall picture of the challenges of staffing rural areas over the period studied.

A general limitation was with access to documentary evidence, particularly during the period covered by the study, in order to track changes in deployment and related policy and implementation over time. Official copies of the government regulations were difficult to obtain and because prior approval had not been sought from the individual FBO authorities, in addition to the overall FBO coordination (e.g. ZACH), it was neither possible to get documents from those authorities. In addition, the researchers were unable to access documents relating to the existing service contracts between government and the FBO, making it difficult to clarify the relation between the two bodies and in addition, the human resource management arrangement for ordained staff.

There were some challenges in securing interviews – especially with national key informants, though there was much greater success at provincial level and below and only a few interviewees declined permission to be recorded which made it harder to produce a true record of what they said, though detailed notes were taken.

One strategy planned for measuring the impact of changing policies was through analysis of routine staffing data throughout the period of the study. However, the data was incomplete, particularly for two districts where data from some facilities was not available at the district office. Because of the way in which the personnel records were stored, and in some cases their incompleteness, it was difficult to get a representative sample across the categories of health workers. In addition, the selection was skewed towards nurses. Nevertheless, the multi-methods approach of this study allowed for qualitative data gathered through interviews with key informants, managers and staff – in particular the job histories (Witter et al in press) - to complement the picture given from routine staff data on the changing staffing situation.

The findings of this study are specific to the context of rural Zimbabwe, but the lessons learnt may be useful for consideration in other contexts.

4.2 Context

This study was designed to review the changes in deployment policy and practice in the context of the crisis and post-crisis periods in Zimbabwe. However, we identified several major areas of change in the broader context that were highly relevant to understand the evolution of deployment. The first is the post-independence desire to improve equitable access to health services by coordinating the fragmented provision of health service which included bringing the then well-resourced FBO facilities into line with government plans and funding. The Presidential Commission of 1999 recommended new structures that would give the health sector some freedom from the constraints of the broader public service to better attract and retain health professionals, as had been done in several other African countries, for example in Ghana with the establishment of the Ghana Health Service in 1996⁴ and Malawi with the establishment of the Health Services Commission in 2003⁵. In Zimbabwe, through the Health Act of 2004, the Health Services Board was established in 2006. All government-funded health providers, including the now less well-resourced FBOs, were brought under one central authority. The Health Service Regulations of 2006, based on the Public Service Regulations 2000, manage the terms and conditions – including recruitment and deployment – of all staff governed by the HSB. The process of bringing the FBO facilities under the single authority of the HSB was slow – which is understandable given the decades in which FBOs had been governed autonomously under church structures – as demonstrated by the low number of service-level agreements reported to have been in place by 2009. This lack of integration into the new structure was also demonstrated by the uneven application of HSR 2006 for government funded health staff working for FBOs – even as late as 2013 when the field work was carried out.

Public sector reforms usually revolve around improving the effectiveness and efficiency of publicly funded services. In times of austerity, the emphasis is usually on reducing the overall spend on public services. As the wage bill is normally the largest share of this expenditure, recruitment for established posts are either cut or frozen, meaning that when a post becomes vacant it remains unfilled. In Zimbabwe, the Public Service Regulations (PSR, 1992) were

⁴ <http://www.ghanahealthservice.org/ghs-category.php?cid=2>

⁵ http://www.aho.afro.who.int/profiles_information/index.php/Malawi:Analytical_summary_-_Health_workforce

updated in 2000 as part of public sector reforms. Despite the health sector's newly-found independence, the Health Service Regulations of 2006 have few differences – especially regarding deployment – compared to the PSR 2000. The health sector had not been immune to the freezing of posts either before the Health Services Act or afterwards. There may have been greater justification for savings in the health sector prior to the crisis. However, the freezing of posts in 2010 and onwards, just as the health workforce was recovering around 2009 after dollarization and the improvement of economic and social conditions, provided major challenges for district and facility level managers, particularly in rural areas, for the delivery of health services. While applying overall civil service reforms equally to all sectors may make sense administratively, introducing restrictive policies affecting staffing to an already under-resourced workforce may have serious implications in the capacity to deliver appropriate services. In the health sector, the fact that recruitment windows did occasionally open for short periods suggests that health officials may have been able to make special case for the sector. There is also a great risk for the future of the workforce as new graduates find they are unable to get an initial posting and will be forced to leave the sector or even the country. Also being unemployed for long periods after graduation instead of being exposed to the mentoring provided during the induction period, bears the risk of de-skilling these new cadres with potential serious implications on their professional performance once they eventually manage to get into the workforce (e.g. “...*they are half baked*” as one senior worker reported).

In contrast, massive losses of experienced health workers, during and after the crisis occurred in the HSB facilities, was attributed to the development of rent-seeking in the health workforce because of the crisis. An analysis of remuneration in five countries, Ghana, Sierra Leone, Zambia, Nepal and Zimbabwe by McPake et al (2013) found that Zimbabwean health workers were more modestly paid than their counterparts in the other four countries and in that regard the demand for improved remuneration by health workers is in line with HRH innovations undertaken in the other four countries and thus is inevitable in Zimbabwe. In wake of these changing contexts in terms and conditions, the post crisis years have seen an internal labour market that is depleting high skills from the HSB and FBO sector. In the other ReBUILD health workforce study a survey on incentives among doctors, EHPs, Nurses and midwives, found that the pull factors for health to attractive sectors were good salaries, additional allowances, and good working conditions (Chirwa et al 2016). The same survey established that as of 2012 most health workers were being attracted to the municipal providers where incentives both, financial and non-financial were better.

During the crisis vacancies increased triggering a pernicious internal labour market that affected rural areas negatively. Average vacancy rates for doctors and EHPs were 50% between 2005 and 2009 (WHO and Global Health Workforce Alliance). Rural based health workers took up posts in urban facilities denuding the remote areas of experienced health workers. (Wheeler, 2010, Dieleman, 2012, MacKinnon, 2010, McPake, 2013, Chirwa et al 2013).

In addition to the structural changes discussed above, working for any of the government-funded employers became less and less attractive because of the falling value of salaries, allowances – when paid – and the general deterioration of working and living conditions. This understandably resulted in high levels of attrition – either resignations or staff informally absconding – and moving into other sectors or to other countries. The introduction of various forms of additional salary and allowances from 2007 which were paid in USD from 2009, did go some way to making the government-funded health sector more attractive again and provided some of the foundations for rebuilding the health workforce until the recruitment freeze was introduced and generally reversed the workforce rebuilding gains.

4.3 The human resource policy and practice response to the crisis and post-crisis situations

Two important policy responses to the impact on staffing shortages in the crisis and post-crisis periods were: 1) the introduction of the Primary Care Nurse (PCN) in 2005 to increase the number of staff coming into the health sector and being retained at the primary care level in rural areas and 2) the introduction of donor-funded retention allowances and top-ups from 2007 onwards (Chirwa, 2014, 2015a, 2015b)

The policy responses to the crisis and post-crisis periods related to deployment, as defined in this study, were modest and in some cases probably unrelated to the crisis. For example, in the transition from the Public Service Regulations (2000) to the Health Service Regulations (2006) only two relevant changes were made: 1) the maximum period of secondment of 3 years in PSR 2000 was lifted and 2) the opportunity for a health worker to make a representation about an intended transfer was introduced. It is unclear what the specific objectives were for introducing changes were. Though the lifting of the time-limit for secondment provides greater flexibility for managers, as we shall see below, this may be counter-productive.

The policy on initial posting of giving graduates three choices of location had to be withdrawn after the recruitment freeze of 2010, as it was no longer possible to provide any choice since vacant posts could not be filled. Once the recruitment freeze has been permanently lifted for the health sector, it would seem appropriate to re-instate the choice of location for new graduates to reduce turnover of staff moving on as soon as they could.

The policy on bonding was changed in response to the crisis and post-crisis periods. Because of apparent sensitivity during the crisis period, the bonding period was reduced – for nurses from three to two years. With such a big staff shortage, and a fluid labour market the government could not afford to drive people away from the sector, so understandably became more lenient. When even the reduced period of bonding was not working the government used the strategy of withholding graduation certificates for a period of time. However, following the recruitment freeze when jobs could no longer be guaranteed both the bonding policy and the policy of withholding of certificates was relaxed.

Finally, the policy on reappointment of staff who had left the service was changed to accommodate the easy and rapid return of staff to the health sector. This policy change appears to have been a bold and shrewd move, especially as the reappointment process to the public service in many countries tends to be a punitive and difficult process to discourage people leaving in the first place especially as the reappointment process to the public service in many countries tends to be a difficult process. Having broken the mould out of necessity, it would be good to retain flexibility to allow re-entry of staff who have left, especially given the volatility of the labour market within the region.

Much of the response to the crisis and post-crisis situations related to deployment was in the actual practice or implementation of the policies and in particular in relation to transfer and secondment (the temporary form of transfer). During the crisis period, vacancies rapidly increased due to unfavourable working conditions (including pay) and living conditions. In these situations, the 'carousel' moves towards urban postings (especially because of the much higher remuneration package being offered by the urban district councils) and migration to other countries (Lehmann et al 2008). The pragmatic response of the district level managers was to be flexible in the use of the transfer rules and to allow staff to move more freely to their preferred locations, as long as there was a vacancy. That way, at least these staff would be retained in the location. FBO managers, however, showed less flexibility and, benefiting from the lack of clarity of the application of HSR 2006 to government-funded employees in their institutions, convinced these employees that they were not free to leave. While this may

provide short-term benefits in retention, in the longer term this is likely to make working from FBOs less attractive.

Unable to use the formal transfer process, and, probably also to avoid the costs of arranging the transfer, district level managers seem to have used the temporary form of transfer – i.e. secondment – as a means of filling vacancies. With the removal of the limitation on length of secondment when the Health Service Regulations were drafted and the lack of paperwork needed, this gave managers even greater flexibility. Our study found several secondments longer than 3 years (see Table 8) in the post-crisis period and therefore after the implementation of HSR 2006. Some new graduates benefited from the secondment process as it was a way of getting around the recruitment freeze. However, as the secondments were mainly to small facilities it meant that they missed out on mentorship during their probation period which has quality implications not only for the start of their careers, but also this poor foundation may have implications for the quality of their work long into the future. A further problem with secondment was the unpopularity with staff partly because of the lack of transparency of the process, lack of certainty when they will be returned to their posts and the additional workload at the temporary posting. Although there was no evidence of health workers leaving the sector because of this treatment, there must have been a significant risk of this happening.

While it is easy to comment on the actions – or to some extent the lack of it – of policy makers in a crisis such as that experienced in Zimbabwe, they would not have been able to predict how long the crisis would last. It is therefore difficult to decide what changes to make to deployment policy even when the health workforce is clearly haemorrhaging. Nevertheless, the bonding policies were clearly adapted at various stages of the crisis and post-crisis periods in response to the changing labour market situation. The shift on the policy of reappointment was clearly triggered by the window of opportunity as health workers who had left the sector were beginning to return. No official changes in the transfer and secondment policies were made specifically in response to the crisis and post-crisis situation.

While the changes in response to the crisis in deployment-related policy might have been limited, adjustments and adaptations at the practice level were more prominent. In particular, the relaxation of transfer rules at the height of the crisis and the tactical use of secondment demonstrated the ability of managers to identify where they have flexibility in implementing policy – what Bossert (1998) refers to as ‘decision-space’ – and to carry out actions to achieve their objectives, which in this case were retaining staff and filling vacancies. Though the

deployment objectives might have been achieved reasonably successfully in the short term, the actions of FBO managers preventing staff from transferring and government managers of forcing staff into short-term secondments, in the longer term staff in both cases may leave at the first opportunity. Hence the longer-term objective of retention would not be achieved. In these situations, managers should be supported to take the initiative to solve problems, but should also be supported in the understanding both the short and longer-term implications of human resource management actions. In addition, managers should be aware of the more complex outcomes of several deployment-related policies – what Buchan (2004) refers to as ‘bundles’ of HRM strategies – might be. In this study, this would mean looking at a bundle of strategies for initial posting, bonding, transfer and secondment, and reappointment.

The same lesson would be useful for national policy makers. As the outcomes of HR policies are often unpredictable, both policy-makers and managers would benefit from better monitoring data which would require better human resource information systems (HRIS). This would also allow for modelling which would help both policy makers and managers to model the impact of policy changes.

Aside from the crisis itself, the recruitment freeze had the biggest impact on deployment – blocking entry and movement once in the sector and for the future of the workforce. While decisions relating to the overall wage bill will be made by central government, the health sector will always be able to make a stronger case for exemptions from the freeze with better data and modelling and a coherent strategy for improving the HR situation.

From our analysis of the findings of this study, we present two sets of recommendations – the first relating to Zimbabwe and where it is now; and the second for other countries imminently emerging from crisis.

Lessons for Zimbabwe

This study was carried out between 2013-15. Policy changes may have been introduced since then, but these lessons are based on the findings of this study:

- 1 Clarify the inconsistencies regarding the status of non-ordained health staff in the large FBO facilities and deployment rules governing them. The FBO is the largest provider of health services in rural areas and if the underlying disaffection by non-ordained staff is not dealt with an exodus is inevitable which will affect rural dwellers.

- 2 The HSB probably needs to be able to negotiate harder with the Ministry of Finance to gain further concessions regarding the blanket freezing of post. This will require better HR information and the development of models to demonstrate both the short and longer-term impact of the recruitment freeze on the health workforce. It will also require a coherent strategy – including the use of deployment-related policies – to demonstrate how the health sector will get greater value from the workforce.
- 3 When it is feasible, the provision of three preferences for the initial posting should be reinstated to improve the chances of retaining staff and the utility of bonding policies reviewed.
- 4 District level managers should be provided with a better understanding of deployment strategies (initial posting, bonding, transfer and secondments, and reappointment) and possible unintended consequences resulting from the use of these strategies. They should then be encouraged to implement the deployment-related policies in the most appropriate way to achieve a balance of vacancy reduction and staff retention.

Lessons for other countries emerging from crisis

- 4 The effects of the changes in the wider policy context on deployment during the crisis and post-crisis periods as well as the actual deployment-related policies on staffing in rural areas need to be understood by policy-makers before deciding how to address problems.
- 5 Human resource management information systems, however basic, across all major employers are needed during crisis and post-crisis period to understand the effects of changes in the wider policy context and deployment-related policies and, where possible, to make appropriate adjustments within the prevailing labour market conditions.
- 6 Local managers need technical support and sufficient authority to adapt implementation of deployment-related policy to address staffing problems. This is particularly needed in times of crisis, but if they are also supported at other times their skills in adapting implementation will be greater. The managers should also be made aware of the unintended consequences of changes to the way deployment policies are implemented and the potential negative consequences for other areas of human resource management.

Conclusion

We compared implementation of posting policies in rural areas in two large employers of HRH, government (HSB) and FBO, in the pre-crisis, crisis and post crisis periods in Zimbabwe. The results have shown that the crisis severely affected the health workforce, triggering considerable attrition and distorting implementation of deployment policies with a particularly detrimental impact on staffing in rural and remote areas. However, while these areas were negatively affected by the crisis in general, during the peak of the crisis and when the value of money collapsed, these areas became relatively more attractive as workers could use coping mechanisms to deal with shortages of basic items such as food or social support.

The study has revealed that there were no main policy changes triggered by the crisis and that most of the changes occurred at the implementation level. The much bigger policy changes that affected deployment were the establishment of the HSB and the 'centralisation' of the recruitment process for HSB staff working in government and FBO facilities. One policy that resulted from the crisis was the recruitment freeze which worked against effective staff deployment. However, the implementation of deployment policy was more responsive to the crisis and post-crisis needs. The relaxation of the reappointment rules by the MoHCC/HSB for workers willing to re-enter the workforce after having absconded or resigned, helped to revitalise the health sector during the emergence from crisis. Responsiveness by managers to local needs, exemplified by the flexible implementation of transfer rules so as not to drive staff away was a factor in infusing resilience in the health service during the crisis. Secondment was used as a pragmatic way of filling gaps, though this was not popular with staff and may have longer term implications. This makes it imperative for managers at local level to be supported in being able to enforce regulations flexibly and in understanding the short and long term positive and negative consequences of their decisions on staff. One critical resource that is vital in supporting managers at all levels in making decisions is an effective and reliable HRIS, which currently is not adequate.

Despite pro-equity centralisation policies introduced after Independence aimed at the unification of all health service providers under the umbrella of one national health system, inconsistent implementation of the agreement between government and FBOs led to workers operating in the mission sector having to deal with two parallel systems which were sometimes ruled by different policies and regulations. FBOs respond to different hierarchies and institutions besides the government (HSB) which sometime dilutes accountability. In addition, FBOs operate with ordained and secular staff and apply different policies to these two groups which cause tensions.

Difficulties in accessing data in the FBO sector didn't allow researchers to fully explain this but the use of in-depth interviews and other methods including life-histories, proved to be complementary allowing for a relatively good body of evidence to explain the phenomenon under study. From the findings and the lack of personnel and staffing data from the FBO sector it is difficult to determine which organisation is implementing deployment policies more effectively. However, there are some differences between both sectors that can provide ideas about the reasons why FBOs may perform better in this regard. A comparative advantage in the FBO sector is that having ordained staff that stay in post for life, do not migrate or transfer and that accept orders including transfer or secondment without discussion makes workforce planning more effective which ensures relatively appropriate staffing levels and a fair share of the workload. Also they have relatively better maintained infrastructures, stronger supply systems and better staff accommodation which increase their retention capacity although secular staff perceived some of the discipline measures as an important reason to request transfer to the HSB sector.

The study revealed the complex nature of the FBO/HSB relationship and identified ways to improve deployment systems to rural areas used by large employers of health personnel post crisis in Zimbabwe.

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Annexes:

Annex A: Job History Summary

DISTRICT 1

CADRE	NUMBER	AVERAGE YEARS AT 1ST POST
PCN	4	0.6
SCN	2	3.4
RGN	6	3
EHT	2	3.6
MIDWIVES	3	1.9

DISTRICT 2

CADRE	NUMBER	AVERAGE YEARS AT 1ST POST
PCN	6	3.5
SCN	0	-
RGN	12	2.9
EHT	5	2.6
MIDWIVES	5	2.7

DISTRICT 3

CADRE	NUMBER	AVERAGE YEARS AT 1ST POST
PCN	2	3.8
SCN	3	3.4
RGN	3	2
EHT	5	1.1
MIDWIVES	9	3.4

Annex B: Personnel Records list

Sample personnel record files by district, facility, sector and gender.

No.	District	Facility Name	Sector	Gender	Cadre
1	District 1	District 1 Hospital	HSB	F	RGN
2	District 1	RHC	HSB	F	PCN
3	District 1	District 1 Hospital	HSB	F	RGN
4	District 1	District 1 Hospital	HSB	F	RGN
5	District 1	District 1 Hospital	HSB	F	RGN
6	District 1	District 1 Hospital	HSB	M	RGN
7	District 1	District 1 Hospital	HSB	M	RGN
8	District 1	District 1 Hospital	HSB	F	RGN
9	District 1	FBO Hospital	FBO	F	PCN
10	District 1	FBO Hospital	FBO	F	SCN
11	District 1	FBO Hospital	FBO	F	MIDWIFE
12	District 1	FBO Hospital	FBO	F	RGN
13	District 1	FBO Hospital	FBO	F	MIDWIFE
14	District 1	FBO Hospital	FBO	F	RGN
15	District 1	FBO Hospital	FBO	M	GMO
16	District 1	FBO Hospital	FBO	M	SCN
17	District 1	FBO Hospital	FBO	M	RGN
18	District 1	FBO Hospital	FBO	F	PCN
19	District 1	FBO Hospital	FBO	F	RGN
20	District 1	FBO Hospital	FBO	M	RGN

21	District 1	FBO Hospital	FBO	M	MIDWIFE
22	District 1	FBO Hospital	FBO	F	RGN
23	District 2	District 2 Hospital	HSB	F	RGN
24	District 2	District 2 Hospital	HSB	M	MIDWIFE
25	District 2	Kana Mission Hospital	FBO	F	MIDWIFE
26	District 2	Kana Mission Hospital	FBO	F	RGN
27	District 2	Kana Mission Hospital	FBO	F	RGN
28	District 2	Kana Mission Hospital	FBO	F	SCN
29	District 2	District 2 Hospital	HSB	M	MIDWIFE
30	District 2	District 2 Hospital	HSB	F	RGN
31	District 2	District 2 Hospital	HSB	F	MIDWIFE
32	District 2	District 2 Hospital	HSB	F	SCN
33	District 2	District 2 Hospital	HSB	M	SIC
34	District 2	District 2 Hospital	HSB	M	PEHT
35	District 2	FBO Mission Hospital	FBO	F	PCN
36	District 2	FBO Mission Hospital	FBO	F	PCN
37	District 2	FBO Mission Hospital	FBO	F	RGN
38	District 3	District 3 Hospital	HSB	F	PCN
39	District 3	District 3 Hospital	HSB	F	SCN
40	District 3	District 3 Hospital	HSB	F	RGN
41	District 3	District 3 Hospital	HSB	F	RGN
42	District 3	District 3 Hospital	HSB	F	SIC
43	District 3	District 3 Hospital	HSB	F	RGN
44	District 3	District 3 Hospital	HSB	F	SCN

45	District 3	District 3 Hospital	HSB	M	RGN
46	District 3	FBO Mission Hospital	FBO	M	RGN
47	District 3	FBO Mission Hospital	FBO	F	PCN
48	District 3	FBO Mission Hospital	FBO	F	RGN
49	District 3	FBO Mission Hospital	FBO	F	MIDWIFE
50	District 3	FBO Mission Hospital	FBO	F	MIDWIFE
51	District 3	FBO Mission Hospital	FBO	F	MIDWIFE

Annex C Study Tools

I. Key informant interviews at (National Level): Topic Guide

RURAL POSTING/DEPLOYMENT OF HUMAN RESOURCES FOR HEALTH: ZIMBABWE

Key Informant Interview (National Level): Topic Guide

Rural Posting <i>Sub-study 3</i>	<i>Identification</i>	Site Code	Interviewer code	Project ReBUILD
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Sub-study 3: Rural Posting/Deployment of Human Resources for Health in Zimbabwe

Key informant interview: topic guide

Introduction: Introduce the study, the scope of the interview

Informed Consent Process: Ensure participant has read the information sheet, ask if she / he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		5. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
2. Date of Interview		6. Age	
3. Place of work		7. Name of interviewer	
4. Title of interviewee			

Topic guide

Explain that you will first ask about the period during the crisis; and then ask about the period after crisis (avoid being too specific about dates).

A. (DURING CRISIS)

1. Evolution of policy during the crisis period

Context and challenges

- a. What were the main challenges for government policy in relation to posting of health workers to rural areas?
- b. Particularly focus on challenges relating to:
 - i. Ability to post enough staff to rural areas
 - ii. Ability to keep them in those areas
 - iii. Deputation of staff
- c. Which cadre of staff were most challenging?
- d. How did the challenges vary across the period (1999 to present day)?
- e. Tell me about the most important context changes over the period which affected health workers

PROBE:

- Economic changes
- Security changes
- Political changes
- Organisational changes /reforms
- International context
- Other

2. Policy response

- a. How did the government react to these challenges?
- b. Can you explain to us how the posting policies changed over time since 1999?
 - Describe each of the policies, including any different policies for the different cadres of staff (check against map or description generated from document reviews and key informant interviews)
 - Ask for the titles of relevant documents which articulate the policies (and ask where they might be available from, if you don't already have them)
 - Do you have any schemes of service? Please describe them. Have these changed over time?
- c. What were the objectives of each policy?
- d. Did the policies build on what went before or not (any learning from previous policies)?
How do the different initiatives relate to one another?

3. Drivers of changes

- a. What were the main factors which influenced the changes in policy? (Discuss for each main policy change described)
- b. Who were the main actors involved in the process of developing rural posting/deployment of HRH policies? How did they bring about the change? What did they do / influence?
- c. What resistance was there to policy changes? Describe this resistance

4. Implementation challenges

- a. Taking each of the policy changes in turn, can you describe to me how they were implemented in the crisis period? PROBE:
 - What were the mechanisms?
 - Over what areas of the country?
 - Focussed on which health workers?
 - Implemented by whom? At what level?
- b. What were the implementation challenges?
 - Were they overcome? How?
- c. What were the strengths in relation to implementation?
 - Describe how they were achieved?
- d. Overall, how effective was the implementation?

5. Effects of the policy change(s)

- a. For each major policy change/intervention described by the KI, ask:
 - Was it ever evaluated? How and by whom? What were the results?
 - What was its overall impact, in your view?
 - How did effects differ across regions? Across cadres? Across ethnic groups? Across genders?
 - How do others view the experience? What lessons have they drawn from it?
 - Did it have any unintended effects (positive or negative)?
- b. Staff turnover
 - i. What was the effect of the policy on the turnover of staff? Give examples of this with numbers
 - ii. Why do you think the policy had this effect?

- c. Staff vacancies
 - i. What was the effect of the policy on the vacancy rates? Give examples of this with numbers
 - ii. Why do you think the policy had this effect?

- d. Improved access to services
 - i. Has the policy enabled people, especially in poorer areas, to access services at reasonable cost and quality (or had the opposite effect)?
 - ii. Explain your answer

- e. Systems effects
 - i. Has the policy affected the wider health system?
 - How?
 - Any positive or negative effects (whether intended or not)? Please describe them (example: depletion of health workers in urban areas)

B. (AFTER THE CRISIS)

To avoid making this section too repetitive, focus on the differences between during and post crisis periods

6. Evolution of policy after the crisis period

Context and challenges

- a. What were the main challenges for government policy in relation to posting of health workers to rural areas?
- b. Particularly focus on challenges relating to:
 - Ability to post enough staff to rural areas
 - Ability to keep them in those areas
 - Secondment of staff
- c. Which cadres of staff were most challenging?
- d. How did the challenges vary during the crisis period?
- e. Tell me about the most important context changes over the period which affected health workers

PROBE:

- Economic changes
- Security changes
- Political changes
- Organizational changes /reforms
- International context/donor funding/ programmes
- Other

f. Policy response

- i. How did the government react to these challenges?
- ii. Can you explain to us how the posting policies changed over time since then?
 - Describe each of the policies, including any different policies for the different cadres of staff (check against map or description generated from method 1)
 - Ask for the titles of relevant documents which articulate the policies (and ask where they might be available from, if you don't already have them)
 - Do you have any schemes of service? Please describe them. Have these changed over time?
- iii. What were the objectives of each policy?
- iv. Did the policies build on what went before or not (any learning from previous policies)? How do the different initiatives relate to one another?

7. Drivers of changes

- a. What were the main factors which influenced the changes in policy? (Discuss for each main policy change described)
- b. Who were the main actors involved in the process of developing rural posting policies?
 - How did they bring about the change? What did they do / influence?
 - What resistance was there to policy changes? Describe this resistance

8. Implementation challenges

- a. Taking each of the policy changes in turn, can you describe to me how they were implemented in the crisis period? In the post-crisis period? Were there any adaptations made?
 - What were the mechanisms?
 - Over what areas of the country?
 - Focused on which health workers?

- Implemented by whom? At what level?
- b. Overall, how effective was the implementation?

9. Effects of the policy change(s)

- a. For each major policy change/intervention described by the KI, ask:
 - Was it ever evaluated? How and by whom? What were the results?
 - What was its overall impact, in your view?
 - How did effects differ across cadres? Across genders?
 - How do others view the experience?
 - Did it have any unexpected effects (positive or negative)?
- b. Staff vacancies
 - What was the effect of the policy on the vacancy rates? Give examples of this with numbers
 - Why do you think the policy had this effect?
- c. Staff turnover
 - What was the effect of the policy on the turnover of staff? Give examples of this with numbers
 - Why do you think the policy had this effect?
- d. Improved access
 - Has the policy enabled people, especially in the poorer areas, to access services more easily (or had the opposite effect)
 - Explain your answer

10. Your recommendations

- a. Based on these experiences both during and after the crisis, what do you think should be done to improve the posting of health workers to rural areas?
- b. Which strategies should be adopted in the future to address the current challenges for rural posting/deployment of HRH?

II. Key Informant Interview (provincial and district level): Topic Guide

RURAL POSTING/DEPLOYMENT OF HUMAN RESOURCES FOR HEALTH: ZIMBABWE

Key Informant Interview (provincial and district level): Topic Guide

Rural Posting <i>Sub-study 3</i>	<i>Identification</i>	Site Code	Interviewer code	Project ReBUILD
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Sub-study 3: Rural Posting/Deployment of Human Resources for Health in Zimbabwe

Key informant interview: topic guide

Introduction: Introduce the study, the scope of the interview

Informed Consent Process: Ensure participant has read the information sheet, ask if she / he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		5. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
2. Date of Interview		6. Age	
3. Place of work		7. Name of interviewer	
4. Title of interviewee			

Topic guide

Explain that you will first ask about the period during the crisis; and then ask about the period after crisis (avoid being too specific about dates).

B. (DURING CRISIS)

11. Evolution of policy during the crisis period

Context and challenges

- f. What were the main challenges for government policy in relation to posting of health workers to rural areas?
 - g. Particularly focus on challenges relating to:
 - iv. Ability to post enough staff to rural areas
 - v. Ability to keep them in those areas
 - vi. Deputation of staff
 - h. Which cadre of staff were most challenging?
 - i. How did the challenges vary across the period (1999 to present day)?
 - j. Tell me about the most important context changes over the period which affected health workers
- PROBE:
 - Economic changes
 - Security changes
 - Political changes
 - Organisational changes /reforms
 - International context
 - Other

12. Policy response

- e. How did the government react to these challenges?
- f. Can you explain to us how the posting policies changed over time since 1999?
 - Describe each of the policies, including any different policies for the different cadres of staff (check against map or description generated from document reviews and key informant interviews)
 - Ask for the titles of relevant documents which articulate the policies (and ask where they might be available from, if you don't already have them)
 - Do you have any schemes of service? Please describe them. Have these changed over time?

3. Implementation challenges

- e. Taking each of the policy changes in turn, can you describe to me how they were implemented in the crisis period? Were any adaptations made?
- f. Overall, how effective was the implementation?

4. Effects of the policy change(s)

- g. For each major policy change/intervention described by the KI, ask:
- What was its overall impact, in your view?
 - How did effects differ across cadres? Across genders?
 - How do others view the experience?
 - Did it have any unexpected effects (positive or negative)?
- h. Staff turnover
- What was the effect of the policy on the turnover of staff? Give examples of this with numbers?
 - Why do you think the policy had this effect?
- i. Staff vacancies
- What was the effect of the policy on the vacancy rates? Give examples of this with numbers?
 - Why do you think the policy had this effect?
- j. Improved access to services
- Has the policy enabled people, especially in poorer areas, to access services at reasonable cost and quality (or had the opposite effect)?
 - Explain your answer

B. (AFTER THE CRISIS)

To avoid making this section too repetitive, focus on the differences between during and post crisis periods

5. Evolution of policy after the crisis period

Context and challenges

- a. What were the main challenges for government policy in relation to posting of health workers to rural areas?
- Particularly focus on challenges relating to:
 - i. Ability to post enough staff to rural areas
 - ii. Ability to keep them in those areas
 - iii. Deputation of staff
- b. Which cadre of staff were most challenging?
- c. How did the challenges vary across the period (1999 to present day)?

d. Tell me about the most important context changes over the period which affected health workers

o Probe:

- Economic changes
- Security changes
- Political changes
- Organisational changes /reforms
- International context
- Other

6. Policy response

a. How did the government react to these challenges?

b. Can you explain to us how the posting policies changed over time since 1999?

- Describe each of the policies, including any different policies for the different cadres of staff (check against map or description generated from document reviews and key informant interviews)
- Ask for the titles of relevant documents which articulate the policies (and ask where they might be available from, if you don't already have them)
- Do you have any schemes of service? Please describe them. Have these changed over time?

7. Implementation challenges

a. Taking each of the policy changes in turn, can you describe to me how they were implemented in the crisis period? Were any adaptations made?

b. Overall, how effective was the implementation?

8. Effects of the policy change(s)

a. For each major policy change/intervention described by the KI, ask:

- What was its overall impact, in your view?
- How did effects differ across cadres? Across genders?
- How do others view the experience?
- Did it have any unexpected effects (positive or negative)?

b. Staff turnover

- What was the effect of the policy on the turnover of staff? Give examples of this with numbers

- Why do you think the policy had this effect?
- c. Staff vacancies
 - What was the effect of the policy on the vacancy rates? Give examples of this with numbers
 - Why do you think the policy had this effect?
- d. Improved access to services
 - Has the policy enabled people, especially in poorer areas, to access services at reasonable cost and quality (or had the opposite effect)?
 - Explain your answer

10. Your recommendations

- c. Based on these experiences both during and after the crisis, what do you think should be done to improve the posting of health workers to rural areas?
- d. Which strategies should be adopted in the future to address the current challenges for rural posting/deployment of HRH?

iii: Personnel record data collection tool

Project 4 – rural posting

Method 4: Personnel record data collection tool

Data collection information:

1. Name of enumerator:
2. Date of data collection:
3. Location (facility or office name):

Personnel record information:

4. Study ID number:
5. Sex:
6. Place of birth or 'home':⁶
7. Nationality⁷:

POSTING INFORMATION (START FROM THE EARLIEST POSTING)

JOB 1

1. Job title:
2. Job grade:
3. Contractual status (permanent, probationary/unconfirmed, fixed-term contract):
4. Name of station (facility):
5. Appointment date (date on initial posting letter):
6. Reasons for Appointment (e.g. filling vacant post, additional posts):
7. Assumption of duty letter date (date the person accepted the job):

⁶ If this is relevant to the policy (e.g. people may be selected for training in their 'home' area)

⁷ Non-nationals should not be included; review inclusion criteria

JOB 2

1. Job title:
2. Job grade:
3. Contractual status (permanent, probationary/unconfirmed, fixed-term contract)
4. Name of station (facility):
5. Appointment/transfer date (date on initial posting letter):
6. Reasons for Appointment/transfer (e.g. individual's request or ministry's order):
7. Assumption of duty letter date (date the person accepted the job):

JOB 3

1. Job title:
2. Job grade:
3. Contractual status (permanent, probationary/unconfirmed, fixed-term contract)
4. Name of station (facility):
5. Appointment/transfer date (date on initial posting letter):
6. Reasons for Appointment/transfer (e.g. individual's request or ministry's order):
7. Assumption of duty letter date (date the person accepted the job):

Use new sheet if more jobs to be included

PROMOTION INFORMATION (START WITH THE EARLIEST PROMOTION)

PROMOTION 1

1. Job title (including if unchanged):
2. Job grade:
3. Reason given for promotion (see circular calling for applications):

PROMOTION 2

1. Job title (including if unchanged):
2. Job grade:
3. Reason given for promotion (see circular calling for applications):

PROMOTION 3

1. Job title (including if unchanged):
2. Job grade:
3. Reason given for promotion (see circular calling for applications):

TRAINING INFORMATION (START WITH THE EARLIEST TRAINING)

INITIAL/BASIC TRAINING

1. Professional qualification:
2. Educational institution:
3. Graduation date:
4. Funding of training⁸:

POST-BASIC TRAINING 1

1. Professional qualification:
2. Educational institution:
3. Entry date:
4. Graduation date:
5. Funding of training:
6. Reason for training (if provided):

POST-BASIC TRAINING 2

1. Professional qualification:
2. Educational institution:
3. Entry date:
4. Graduation date:
5. Funding of training:
6. Reason for training (if provided):

POST-BASIC TRAINING 3

1. Professional qualification:
2. Educational institution:
3. Entry date:
4. Graduation date:
5. Funding of training:
6. Reason for training (if provided):

⁸ Usually government

IV. In-depth Interview (with job history) with health care providers

RURAL POSTING/DEPLOYMENT OF HUMAN RESOURCES FOR HEALTH: ZIMBABWE

In-depth interview (with job history) with health care providers: Topic Guide

Rural Posting <i>Sub-study 3</i>	Identification	Site Code	Interviewer code	Project ReBUILD
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Sub-study 3: Rural Posting/Deployment of Human Resources for Health in Zimbabwe

In-depth interview (with job history) with health care providers: topic guide

Introduction: Introduce the study, the scope of the interview

Informed Consent Process: Ensure participant has read the information sheet, ask if she / he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		5. Type of health care provider	
2. Date of Interview		6. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
3. District		7. Age	
4. Facility name		8. Name of interviewer	

Topic guide

I would like to understand about your career. Can you draw me a line, starting with your birth, and leading to the present day? Please put all your training and jobs on this line with the dates. What are the other major events that you would put on it? Suggestions to include: marriage, birth of first child, training, different jobs. Describe them to me briefly.

Allow respondent to draw the whole life history. Then using that diagram focus on and explore their career both during and after the periods of crisis with probing questions, such as:

- a) How did you come to work in the health field?
- b) What basic training (pre-service) did you have? How was this training funded?
- c) For each job:
 - i. When was that job? (Start and end times for each job)
 - ii. Tell me about the job – what was the title, where was the job (type of facility), what did you do there?
 - iii. Why did you take that job? Is this the job you wanted or did you want to go somewhere else? Why?
 - iv. How were you posted to that job?
 - o Tell us about the administration procedures that you went through to be posted to this job? What were the rules at that time?
 - o What do you think about these procedures?
 - o Did you have any help in getting this job? Who helped you and how did they help?
 - v. Did you try to change your job at any time? How did you go about doing this? Was it successful and why? Was it not successful and why?
 - vi. What do you understand about the rules and regulations of posting at this time?
- d) What post basic training have you had during your career (e.g. upgrading from enrolled nurse to registered nurse or training in midwifery, administration, community nursing etc.)? What were the selection criteria for this training? Is there any preference for people who have worked in rural areas? How was this funded?
- e) What are your future job plans? How do you think the current deployment policies and systems will support these plans?

V. In-depth Interview with managers (overall manager for deployment): Topic Guide

RURAL POSTING/DEPLOYMENT OF HUMAN RESOURCES FOR HEALTH: ZIMBABWE

In-depth interview with managers (overall manager for deployment): Topic Guide

Rural Posting <i>Sub-study 3</i>	<i>Identification</i>	Site Code	Interviewer code	Project ReBUILD
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Sub-study 3: Rural Posting/Deployment of Human Resources for Health in Zimbabwe

In-depth interview with managers (overall manager for deployment): topic guide

Introduction: Introduce the study, the scope of the interview. We are looking at the deployment rules and how they have been implemented in the crisis and post crisis period (i.e. from the late 90s)

Informed Consent Process: Ensure participant has read the information sheet, ask if she / he has any questions or areas for clarification, explain about confidentiality including recording the interview, complete consent sheet.

Details of participant:

1. Interviewee ID		5. Job title and cadre ⁹ of interviewee	
2. Date of Interview		6. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
3. District		7. Age	
4. Facility name		8. Name of interviewer	

⁹ E.g. Health Centre in-charge - registered nurse; or District Medical Officer in-charge –doctor [check]

Topic guide

I would like to understand about how the system of posting/deployment has changed over time (in particular from the late 90s) and the impact on your ability to fill vacancies, particularly posts that are in remote areas. First I would like to ask some questions about your role.

1. Experience in managing deployment

- a) How long have you been managing deployment in this current post?
- b) Were you managing deployment in previous jobs where and when?
- c) What does your job involve in managing the deployment process?
- d) Perhaps you can give us an example of a recent posting that you managed.

Explain that you will first ask about the situation in the period during the crisis; and then ask about the situation in the period during the crisis; and then ask about the situation in the period after crisis (avoid being too specific about dates).

2. Changes in ability to fill posts (during crisis)

- a) What did you notice during this period regarding vacancy levels and turnover in health facilities where you were working (ask for the name(s) of the districts)? Any differences between facilities in urban and rural parts of the district?
- b) For which cadres have there been the biggest changes? (Discuss any staffing data identified analysed from the routine data collection (Method 5),
- c) Can you offer any explanation for these changes?

3. Deployment rules (during conflict)

- a) What were the rules on deployment and transfer were made during this period? Did these rules change during this period? If so, how? Prompt regarding formal policies/rules: criteria for first posting; years of service in each posting; spouse; access to training and who funds; inter-district transfers; bonding; HSB assumption of recruitment responsibility.
- b) Are there any locally made rules?
- c) Were there any rules made specifically for the crisis period e.g. relating to staff security?

Now we would like to take each of the rules you have mentioned:

- a) How did these changes affect the way you (or other people) managed deployment? (Identify the key actors making the decisions). Probe for specific issues identified in the document review and key informant interviews.
- b) Do any of the changes in deployment rules explain the changing vacancy levels and turnover discussed earlier? Probe on which ones and how?
- c) Were there any specific challenges in implementing the rules? Probe for issues related to knowledge of the policy, or adequate HR information. Probe also for issues of pressure to bypass policy in the deployment of staff, either within the district or from higher levels.
- d) Are there any other factors (availability of more staff or big project) that have influenced the effectiveness of the deployment rules – either positively or negatively? Probe for specific issues identified in the document review and key informant interviews.

Post-crisis

4. Changes in ability to fill posts (post-crisis)

- a) What have you noticed during this period regarding vacancy levels and turnover in health facilities where you are working now? If the person worked in other districts in the post conflict period, ask about the situation in those districts (note the name of the district). Any differences between facilities in urban and rural parts of the district?
- b) For which cadres have there been the biggest changes?
(Discuss any staffing data identified analysed from the routine data collection (Methods 5), and talk through any significant changes.)
- c) Can you offer any explanation for these changes?

5. Changes in deployment rules (after conflict)

- a) What are the current rules on deployment and transfer? Have these rules changed during this period? If so, how? Prompt regarding formal policies/rules: criteria for first posting; years of service in each posting; spouse; access to training and who funds; inter-district transfers; bonding; HSB assumption of recruitment responsibility. Were

there any policies made specifically for the crisis/post crisis period e.g. relating to staff security?

Now we would like to take each of the rules you have mentioned:

- a) How did these changes affect the way you (or other people) managed deployment? (Identify the key actors making the decisions)
- b) Do any of the changes in deployment rules explain the changing vacancy levels and turnover discussed earlier? Which ones and how?
- c) Were there any specific challenges in implementing the rules? Probe for issues related to knowledge of the rules, or adequate HR information. Are there any issues of pressure to bypass policy in the deployment of staff, either within the district or from higher levels?
- d) Are there any other factors (availability of more staff or big project) that have influenced the effectiveness of the deployment rules – either positively or negatively? Probe for specific issues identified in the document review and key informant interviews.

6. Suggestions for improving deployment

- a) Based on your experiences what you think should be done to improve the posting of health workers in rural areas?

7. Closure

- a) Is there anything that you would like to ask me?

The interviewer thanks the interviewee for their time and explains how the information will be analysed and the findings of the study disseminated