Biomedical Research & Training Institute

ReBUILD Consortium

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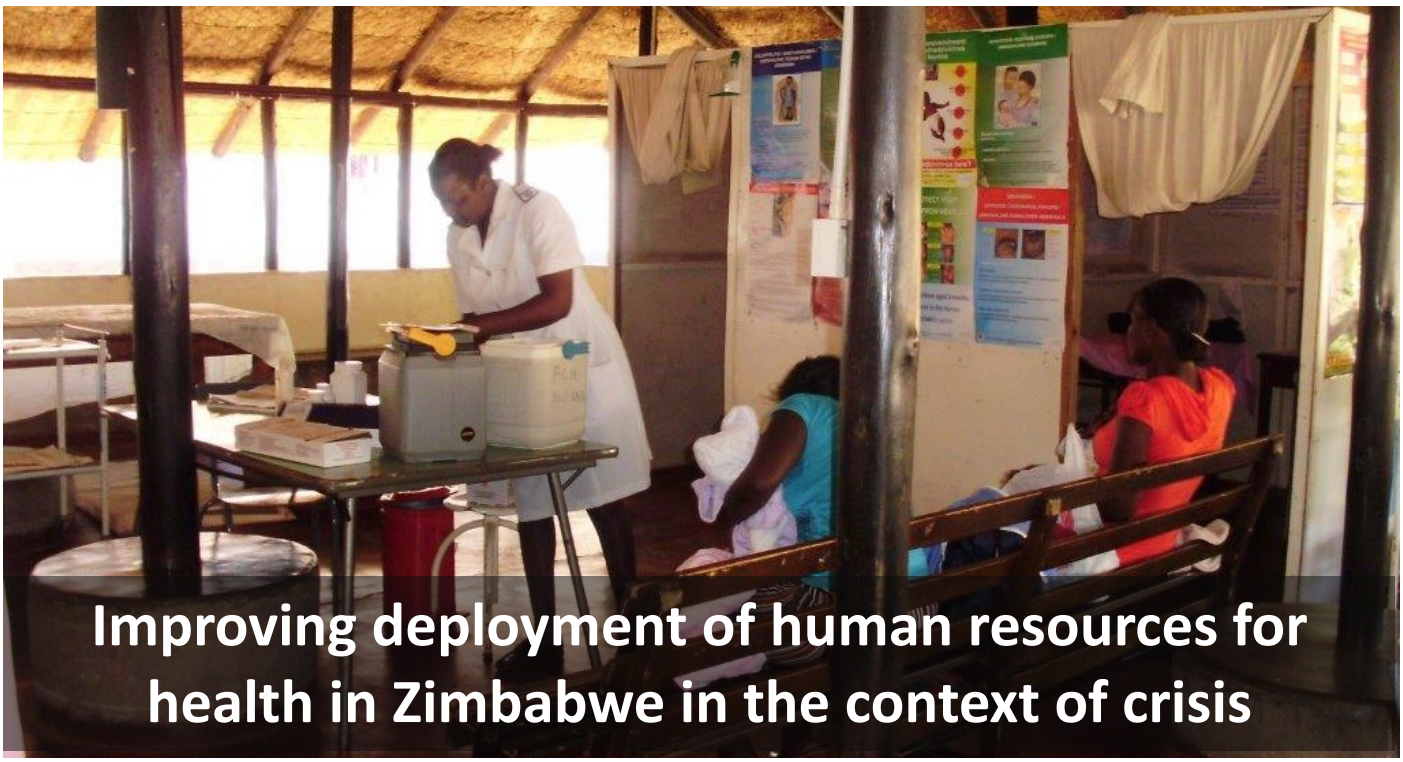
Briefing



Improving deployment of human resources for health in Zimbabwe in the context of crisis

Findings from ReBUILD's research on health worker deployment in Zimbabwe

Background

Appropriate deployment of health workers is critical for ensuring that health services are adequately and equitably staffed. Deployment determines availability of health workers through initial and subsequent posting of staff as needed. The related human resource management (HRM) functions include recruitment, bonding and transfer. The success of these functions is determined by the use of policies that are suitable to the context and appropriate implementation of the policies by managers down to the service delivery level.

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 saw rapid expansion and improved access to health services for the population. In 2008 at the peak of the crisis, health workforce spending accounted for 0.3% of the public health budget which caused massive migration of health workers. Attrition due to migration of disaffected health workers was already a problem before the crisis but the staffing situation in the period 2000 to 2009 worsened. Between 2005 and 2008 an average vacancy rate of 50% subsisted for critical health workers and in 2008 at the peak of the crisis the vacancy rates were-doctors 54%, EHOs 47% and nurses 28%. Acute maldistribution and shortage of critical cadres like doctors, clinical officers and nurses, particularly midwives was recorded in rural areas during and after the crisis a period. As the economy improved and the US dollar was introduced in 2009, more health workers returned to the service. Retention was addressed by the introduction of incentives from 2007. The improvement of health service staffing was curtailed in 2010 with the freezing of recruitment across government (See figure 1). So how, during this period, was the policy and practice of deployment adapted to this changing context in the health sector in Zimbabwe?

Important related changes took place during this period. There was a gradual merger of FBO service provision with government, with government-funded staff in FBO facilities managed using regulations of the Public

Service Commission. These regulations were revised as part of the Public Sector Reforms of 2000 (PSR2000). In 2005 the Health Services Board was created to employ all government-funded health staff using the Health Service Regulations of 2006 that were largely based on PSR2000.

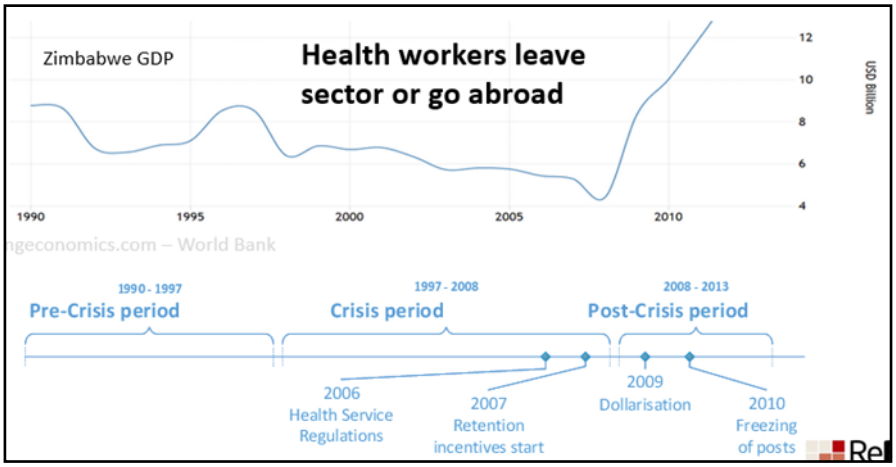


Figure 1: changes in context during the study period

Approach to ReBUILD's research into health worker deployment in Zimbabwe

The ReBUILD consortium carried out research on how the policy and practice of deployment adapted to changes context – both with different forms of crisis - in the health sector in Uganda and Zimbabwe. The aim was to identify lessons for the participating countries, but also to inform policy-makers in other countries affected by crisis. The studies examined deployment systems used by two large employers. In Zimbabwe these were the government health services and services provided by in three districts level in Midlands Province and services provided by a large Faith Based Organisation in the same districts. Some staff in the FBO facilities were employed under government conditions of services, while ordained staff were employed under conditions of service of the relevant dioceses.

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

A total of 17 key informant interviews were conducted at national level. Across the three districts, in-depth interviews were conducted with 11 facility managers (4 from FBOs) and with 67 health workers (including job histories) – 22 from FBOs – covering which cadres: midwives, general nurses and environmental health practitioners.

Key findings:

Overall there were few changes in policy related to the human resource management functions linked to deployment. However, the study identified adaptations in the implementation of policy at district level and below. These findings are presented under the headings of recruitment, bonding, transfer and secondment.

Recruitment

Initially the policy was to give health workers preferences at the recruitment stage for their initial postings. Due to the critical shortages during and after the crisis this choice was not given and managers need to do their best to fill vacancies, particularly in rural areas. Normally, if a health worker workerleaves the service, rejoining is a lengthy process. As conditions improved and large numbers of health staff wanted to return, the HSB issued a circular in 2009 to streamline the process to allow for reappointment within as little as a month. l

"*we found that we had a lot of reappointments, as soon as they heard that there was this US dollars, we had a lot of applications seeking reappointments from the nurses…" (*District Manager)

After the freeze in 2010, recruitment only took place when some positions were opened in 2012 and 2013. New graduates would register the ir availability with the HSB for when positions opened. FBOs were subject to the same recruitment processes and restrictions, except for their ordained staff.

Bonding

Bonding policies were not reflected in the two main HRM policies (e.g. PSR 2000 and HSR 2006) but were self-regulated by professional associations. 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. However, with the introduction of retention incentives some managers felt that the bonding policy became. Then, following the introduction of the recruitment freeze, the bonding policy was discontinued as new graduates were no longer guaranteed a job on graduation. They were free to seek employment in the private sector.
The same bonding policies applied to government staff working in FBOs, but for ordained staff their deployment is managed by the relevant diocese.

Transfer

The policy in the PSR 2000 was that government staff should be transferred after three years in post. HSR 2006, changed to "*for such a period as the Board may determine*". In the pre-crisis period workers' needs and preferences were considered. Particularly family reunification was often mentioned as a reason to request transfer. There was no clear policy response regarding transfers because of the crisis. Managers tried to become stricter in approving transfers because of the shortages, or in some cases requesting health workers to arrange 'swaps' (lateral transfers) with health workers in other posts with mutual interests in transferring. However, there was an upsurge of health workers wishing to transfer for personal reasons – "*people were transferring like hot buns*" - and managers felt they had to be pragmatic or risk having the health workers leave These movements were later restricted after introduction of the recruitment freeze in 2010.
While FBO managers said that government staff could easily transfer between FBO and government facilities, staff found it difficult. They were both afraid to make the transfer request but also lacked sufficient information on the procedure for making the request. This was the case in the pre-crisis period, but managers seemed particularly concerned about not being able to fill vacancies after the recruitment freeze. FBOs used a regular rotation process for ordained staff to cover vacancies in more difficult-to-staff facilities.

Secondment

While the duration of secondments were limited to three years in PSR 2000, the period was left open in HSR 2006. Managers appeared to use this deployment option as best they could to fill vacancies. Secondment is also used as a mechanism to fill vacancies while waiting for approval posts by the central authorities (e.g. Ministry of Finances) during the freeze. Seven of the 67 (10.5%) staff interviewed had been seconded during their working life.
An advantage for managers is that secondment of staff requires minimal paperwork. However, without a formal letter, staff felt that the policy was being implemented in an arbitrary way and they were unclear for how long they would be seconded. Secondment was usually to lower level facilities with high workloads – often FBO facilities – and was therefore unpopular. FBO managers complained of the lack of involvement of the selection of seconded staff and the uncertainty of the period of secondment.

Implications for policy and practice of deployment

Though the use of deployment policies suitable to the context is critical to ensure appropriate staffing of health services, in spite of major changes in the context due to the economic crisis and its aftermath, the

study found little change in policies. The one exception was the circular from the HSB that allowed for a more streamlined approach to reappointment of staff. In contrast, managers who are responsible for ensuring the best staffing of their health facilities at all times, adapted the implementation of the policies. For example, being more lenient with transfers in order not to lose staff; or using secondment in a pragmatic way. While it might be desirable to have more flexibility at the policy level, although some changes can be made quickly by circular, this can be a cumbersome process as in spite of some independence of the HSB, policy is ultimately governed by the PSC. The focus at the policy level in the latter years covered by the study was probably more appropriately making a special case for the health sector to have the recruitment freeze temporarily lifted. This struggle appears to have continued until recently. For more rapid response to changing contexts, it may be a better option to focus on the implementers of the deployment policies – managers at district and facility level. The study has demonstrated that they can modify the implementation of policies partially to address the needs of the staff – thus reducing unnecessary attrition – and the service delivery needs. However, this balance is difficult to maintain and there were indications that, if pushed too hard with secondment for example, staff would be more likely to leave. Managers would benefit from a greater understanding of deployment-related strategies and their possible unintended consequences.

The study showed that a number of relevant policies – such as giving preferences for initial posting and bonding staff after training – have disappeared as a result of the crisis. These could be reviewed for their current relevance and revised if appropriate.

The study revealed some inconsistencies between HSB policy and the way this was being implemented for government staff working in FBO facilities. This should be further examined to confirm whether such inconsistencies have been resolved or not.

Recommendations:

In summary, the areas for further consideration to improve policy and practice for deployment and to prepare for future changes in context are:

- Continue to argue the special case for the health sector to be exempted from freezes on recruitment
- Provide District level managers 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.
- Review, revive and revise, as necessary, deployment-related policies such as posting preferences at recruitment and bonding.
- Clarify the inconsistencies regarding the status of government health staff working in FBO facilities and deployment rules governing them.

For more information, see: Chirwa, Y., Chandiwana, P., Pepukai, M., Mashange, W., Buzuzi, S., Munyati, S., Martineau, T. and Alonso-Garbayo, A. 2016 ***Deployment of Human Resources for Health in Zimbabwe: Synthesis report*** ReBUILD RPC Working Paper. Available at http://bit.ly/2CbgCR2

The ReBUILD Research Consortium is an international research partnership working to support improved access of the poor to effective health care and reduced health costs burdens in settings affected by conflict and crisis. ReBUILD's partner in Zimbabwe is the Biomedical Research and Training Institute (BRTI). To find out more about ReBUILD's work, visit: **www.rebuildconsortium.com**

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