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COVID- 19 and its Impact on Human Resources for Health Deployment: The Zimbabwe Ministry of Health and Child Care Perspective

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Abstract

This research discusses the impact of COVID-19 on human resources deployment in the Zimbabwe Ministry of Health and Child Care (MOHCC). Documentary research and in-depth interviews aided in interrogating the impacts of the pandemic on the deployment of the MoHCC health workforce to meet the increased demand and workload especially in COVID-19 red zones. Research pointed to pressure on the deployment of health professionals dealing with disease detection, screening of patients and case management. COVID-19 can be viewed as a test on the Health Service Board's deployment strategies. Registered nurses' deployment rose from below 45% to 95% in the last quarter of 2020 resulting in the Treasury adopting a policy shift, easily concurring to increase the establishment of frontline nurses based on workload requirements as well as recruiting from outside the MoHCC. This culminated in an improved nurse-patient- ratio and revitalisation of human resources planning mechanisms leading to the adoption of Information Technology in human resources planning and management processes. The adoption of website-based recruitment and deployment framework improved turnaround time in the deployment of health professionals. As COVID-19 continues, the use of scientific human resources planning tools like WISN are highly recommended in providing essential evidence to inform the basis of deploying health professionals at different Ministry's health facilities.

Keywords: COVID-19, Ministry of Health and Child Care, human resources deployment

1. Introduction, and background

The COVID-19 pandemic has greatly affected the effectiveness of health systems globally, especially balancing additional service delivery needs essential to manage the pandemic while advancing access to essential health services (World Health Organization; 2020). The health workforce is a critical component of the pandemic response yet are also among the most exposed to infection and mental health impacts (World Health Organization; 2016). The performance of health care systems is a function of the availability, know-how, skills mix and motivation of personnel delivering services (Mudyarabikwa and Mbengwa 2006). Health human resources are key determinants of the success or failure of health systems (WHO 2000). Despite the health workers being the backbone of any health system, Zimbabwe is badly affected by the shortage of health professionals especially in the categories of doctors, nurses and pharmacists. The health worker crisis was perpetuated by the advent of COVID-19 which required more health professionals to help reduce its impacts. According to WHO (2020) by 10 April 2020, more than 1.4 million confirmed cases of COVID-19 and over 87,000 deaths had been reported, affecting more than 200 countries, areas and territories (WHO,2020). Out of the COVID-19 reported cases to WHO by 8 April 2020, 22,073 were health workers from 52 countries. As of 18 August 2021, Zimbabwe had 121,046 recorded cases and 4156 deaths (www.worldometers.info). Mashange et al (2019) argue that Zimbabwe's response to the crisis (as evidenced in 1997-2008) in deployment-related policy might be limited as adjustments and adaptations at the practice level, in relation to transfer and secondment, were more prominent. This supports Bossert's (1998) assertion that the relaxation of transfer rules at the height of the crisis and the tactical use of secondment demonstrated the ability of managers' flexibility in implementing policy. To effectively manage the COVID-19 crisis, the MOHCC and the Health Service Board had to respond by increasing the deployment of its frontline professionals like nurses and port health officers. Deployment is defined as encompassing the Health Service Board (HSB) functions of getting staff into posts and managing subsequent movements: recruitment, bonding, transfer and secondment (Health Service Act, Chapter 15, 2005). In tandem with this, the research aimed at analysing the impacts of the pandemic on the HSB function of deployment. The article is guided by the following research questions,

What were the major impacts of COVID-19 on the MoHCC Human Resources for Health Directorates?

How did COVID-19 affect the MoHCC deployment policies?

Which of the MoHCC deployment strategies delay the deployment of workforce during disaster situations?

2. Literature Review

There is a general shortage of health professionals in Zimbabwe which worsened during the economic and political recession (Mukunugwa 2012). Factors contributing to health worker shortages before the COVID 19 period are varied and include attrition. Attrition of health workers in the public sector is due to factors that mainly relate to lack of incentives, poor

salaries and conditions of services (Paulinus et al 2000). According to Mudyarabikwa and Mbengwa (2006), the different strategies employed to retain staff in the public sector have had a mixed impact on the distribution of health workers, mainly because of a lack of complementary policies between the other public sector departments and the MoHCC. Employee retention as a panacea to attrition is viewed as encouraging employees to remain in the organisation for a long time (Bernard Nkala et. al. 2021; Das and Bruah 2013). Due to competition, employee retention needs to be at the core of any business to meet its operative requirement. According to Somane (2018), as of 28 February 2018, Harare Central Hospital had 283 doctors and 157 posts were not filled indicating a very high vacancy rate for such critical staff category. Pharmacist staff establishment had 21 cadres in the post out of 26 and nutritionists had 21 vacant posts (MoHCC, 2018). The major challenge is that critical health professionals terminate their contracts in search of greener pastures or to join the private sector. MoHCC complains of poor employee retention policies. Given the critical health staff shortages experienced before the advent of COVID-19 as indicated by Somane (2018), one wonders how dare the situation became after the advent of COVID-19.

According to ILO Sectoral Brief (2020), the COVID-19 pandemic is placing health workers in exceptionally demanding situations. Low staffing levels, predominantly nurse-patient ratios, are frequently related to the spread of pathogens in health care settings and the risk of outbreaks (World Health Organization; 2016). In addition to a heavy workload, they are coping with the fear of contracting the disease and of spreading it to their family and friends. The rapid escalation in the number of cases around the world highlights the urgent need to strengthen less-resourced health systems to respond to the COVID-19 outbreak (Hapmann, 2020) This includes addressing health workforce challenges and scaling up laboratory diagnosis facilities, disease surveillance mechanisms and risk communication strategies. Resource needed to be diverted to enable health departments to improve their resilience to the pandemic. The Government of the United Kingdom, for example, has assigned US$ 6.1 billion, as part of its biggest fiscal stimulus in 30 years, to support its National Health Service (Russell 2020). The demand for health professionals has been evidenced by increases in job vacancies in the health department whilst many employees' contracts were terminated. As given by www.healthsystemtracker.org in the United States, physicians' offices experienced a 2% increase in employment in May, and the offices of other health practitioners also saw a 10% increase in employment. Hospitals (-2%; -122,000 jobs) and nursing and residential care facilities (-4%; -123,000 jobs) had relatively fewer job losses through April but were among the few settings to continue losing jobs in Ma

ILO (2020) notes that the COVID-19 crisis is drawing attention to the already over-burdened public health systems in many countries and to the challenges faced in recruiting, deploying, retaining and protecting sufficient well-trained, supported and motivated health workers. It highlights the strong need for sustainable investment in health systems, including in the health workforce, and decent working conditions and equipment (ILO,2020). Health workers take critical measures to prevent COVID 19 transmission in health care settings, reinforce preventive measures and respiratory etiquette (Nkala Bernard, 2020; WHO, 2020).

3. Methodology

The study followed a qualitative approach relying on both primary and secondary data on Human Resources for Health in the Zimbabwe public sector. Secondary data in form of the Deployment Database, was readily available thus its arrangement in batches and health categories made it easy for the study to analyse the trends and gaps thereof. Data on Health workforce Deployment trends and decisions in the MoHCC was accessed from HSB and the Ministry Human Resources for Health Human Resources Directorates, however limiting to the period March 2020 which marked the first reaction by the government announcing the first case of COVID-19 to January 2021.The period becomes sufficient as it presents the peak of COVID-19 and recorded a rise in the utilisation of high dependency Units (HDU) and Intensive Care Units (ICU) at designated COVID-19 health facilities. At the same period, the demand for health workers like environmental health, nurses, doctors, and port health officers became on-demand as the Ministry announced publicly its commitment to ensuring the safety of both the public and frontline health workers.

The research followed a purposeful sampling to conduct in-depth interviews mainly to verify policy decisions or gaps of the Ministry on deployment during the disaster period (COVID-19), impact of the pandemic on deployment, the most health categories affected by deployment during COVID -19 and established the proposed intervention measures. The in-depth interviews were also used to verify and validate the reported data in line with policy positions taken in view of COVID-19. Therefore, interviews supplemented the main findings on the replenishment rates for selected staff categories during COVID-19. The key informants comprised of the human resources practitioners manning the deployment desks at the Ministry and Health Service Board, the Heads of Health institutions that were requesting workforce during the up surge of COVID-19 infections in Zimbabwe. In this case, central hospitals that were designated COVID-19 testing centres were included in the analysis.

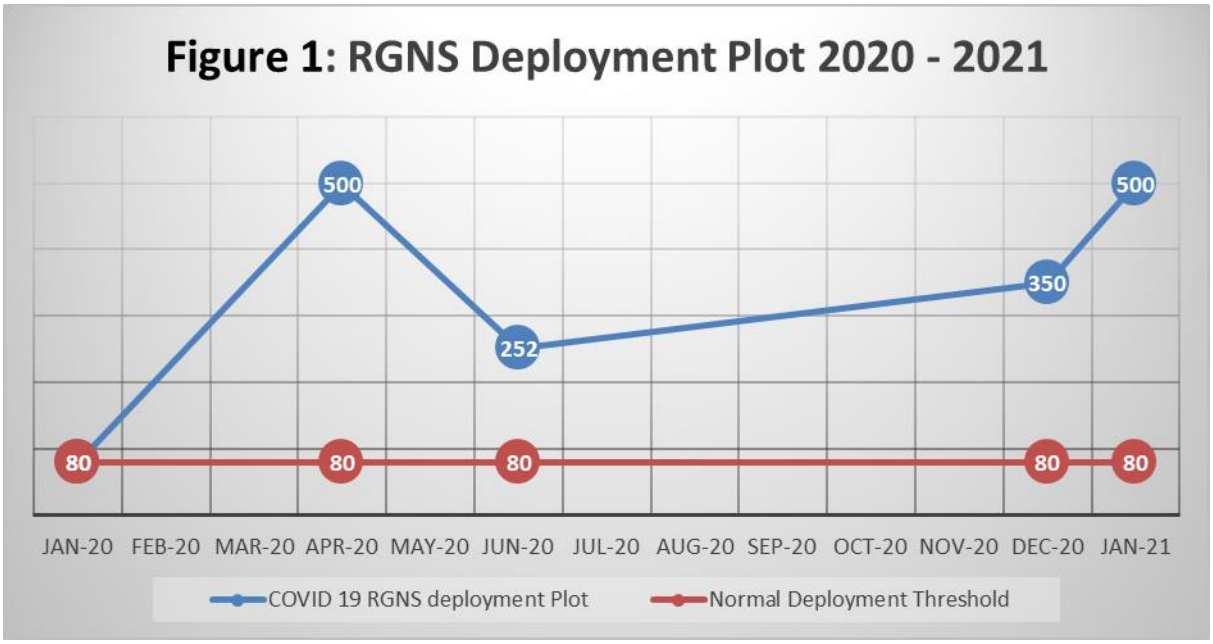
The Deployment policies and the Ministry Reports on COVID-19 to the National Taskforce were reviewed picking the bottlenecks in the Deployment strategies for the HSB and the Ministry. In order to maintain confidentiality of data, the study sought permission to access the Data Base and all views expressed by informants were coded by allocating a number to protect the participants.

4. Research Findings

4.1 The Deployment Rate Increased

The COVID-19 surge exerted pressure on the deployment of health professionals directly dealing with detection of the disease, screening of patients and case management at Health institutions across the country. Before the country recorded its first case in March 2020, the absorption rate of nurses into service was rather low (below 20%) with qualified Registered General Nurses (RGNs) having to wait for deployment for several months from the centrally controlled Health Service Board Recruitment and Employment Database. However, with the growing need to increase screening efforts at public health institutions, the demand for RGNs went up due to the increased workload. In response to arrest the growing number of

COVID-19 infections across the country, the deployment of RGNs rose to above 95% in the last quarter of 2020, with Treasury for the first time willingly concurred to increase the staff establishment of Nurses, Environmental Health Officers and Port Health Officers based on workload requirements. Although there was no scientific study to calculate the exact workload at the health facility, the Government through its national COVID-19 Taskforce concurred that there was increased workload due to the increase in the number of detected cases at all levels of care. In the past, fiscal space would detect the prioritisation of absorbing more cadres like RGNs into service mainly in form of replacements but following the recorded number of deaths in the country, the Ministry had to guide on nursing requirements based on COVID-19 workload needs. Figure 1 indicates the increased nurses' deployment rate between 2020 – 2021.



Source. HSB Nurse Deployment Database 2020 – 2021

4.2 Improved Nurse-Patient Ratios

The COVID-19 pandemic has contributed immensely to the improvement of the country's nurse-patient ratio across the board through increased deployments. Almost in every quarter of 2020, the need for RGNs and other frontline health workers has been increasing owing to the call to increase staff to adequately deal with testing and screening for COVID-19. In the first quarter of 2021, the Ministry received concurrence to employ 500 additional nurses in response to the COVID-19 pandemic which has caused shortages at health facilities as some nurses are falling sick and having to go on mandatory quarantine for 2 weeks. In some cases, the COVID-19 pandemic has been causing deaths. The effects of mandatory quarantines for nurses forced the employer to run short of qualified RGNs to deploy as the training capacity at various nurse training schools could not produce numbers matching the need. According to HSB Employment Database as of February 2021, there were only 200 nurses awaiting deployment against the need of 500. The Health Service Board had to rely on the anticipated

300 nurse graduates who were to graduate from training. However, there is no guarantee that there would be a smooth in-flow of graduates from nurse training schools as there are other variables that come into play.

4.3 Policy Changes - Ministry of Health and Childcare & HSB

The pressure to meet the staffing requirements at public health institutions has led the employer and the Ministry to resort to adjusting its policy stance on recruiting nurse cadres trained outside Ministry's training schools i.e., from UZ, ZDF, NUST and other local Universities including outside the country. This policy approach is likely to have effects on quality standards and compromise professional uniformity expectations in the long run.

The rise of COVID-19 cases in the country provided a huge test for human resources deployment strategies. The Ministry's Human resources department faced an increased call for the environmental health personnel dealing with follow-up of COVID-19 cases. In the past, the environmental staff category had no chance to be easily absorbed into the health service due to the slow rate of replacements. The COVID-19 surge presented the need for the Ministry to increase the number of cadres with environmental health practice to assist in manning Ports of entry areas and conducting follow-ups where there had been reported cases of COVID-19. Before March 2020, the HSB Employment Database had over 4000 Environmental health professionals but as of January 2021, all cadres had been deployed indicating intensive deployment in response to COVID-19 pandemic. Critical specialist skills like Laboratory Scientists recorded a 100% deployment increase as the government needed to increase the workforce teams in the provinces conducting testing for COVID-19 at certificated Laboratories.

As of January 2021, specialist cadres like Pharmacists were now very difficult to find following massive deployment in 2020 responding to the staffing demand from COVID-19 related workload. However, it remains underlined that it has always been very difficult to retain these specialist skills in the public health sector due to low attraction and retention packages offered within the government. Therefore, during the rise of COVID-19 in the country, the private sector was equally competing for specialist skills leading to several health professionals leaving the government for attractive conditions of service. Such untimely movement of employees took the Health Service Board and the Ministry Human Resources deployment interventions one step forward and ten steps backwards as there was continuous hiring and deployment. In some cases, the Board and the Ministry had to deal with health worker preferences on deployment as some professionals like nurses were no longer preferring to be deployed at busy health institutions especially those with COVID-19 isolation facilities.

The need to adequately staff the newly designated COVID-19 isolation centres exerted pressure on the Ministry to find specialised health professionals to deal with Intensive Care Units (ICU), High Dependency Units (HDU) and general isolation wards (Nkala Bernard, 2020). The Ministry found it very difficult to incentive medical specialists i.e., doctors and none was prepared to be deployed to COVID-19 red zone sections. As of January 2021, the Ministry had recorded over 1200 health workers diagnosed COVID-19 positive, forcing all

the health workers who tested positive to go on mandatory isolation. Consequently, this had serious consequences on finding alternate replacements to be deployed to such sensitive areas like the ICU and HDU within public health institutions. To add to the complexity of the issue, by February 2021 the Ministry's prospective employment database had been depleted to less than 5% across all disciplines that are deployed after training.

4.4 Reduced Rate of Filling Critical Posts

The other effect of the COVID-19 pandemic was recorded on the reduced rate of filling critical posts by the employer through the promotional framework. Due to the COVID-19 restrictions, there had been reduced interface with candidates forcing the Health Service Board to suspend holding face to face interviews with all candidates. The suspension of face-to-face assessments led to delays in filling critical service posts essential in dealing with the COVID-19 disease. The rate of filling critical managerial posts reduced to less than 30 % from about 80% in the period July to December 2020. The reduction of the workforce to about 10% of the total workforce across health institutions brought a lot of dis-service on the deployment processes as the processing of urgent deployment queries and cases by HR practitioners would now delay by approximately 90% of the normal cycle. During the reduced work schedules, human resources work processes could not be completed timeously resulting in unnecessary delays as some human resources practitioners were even afraid to directly handle enquiries of those who physically visited the Ministry of Health Service Board human resources Directorates.

4.5 Revitalisation of the Human Resources Planning Mechanism

One of the positive effects realised from COVID-19 pressures is the revitalisation of human resources planning mechanism leading to the adoption of Information Communication Technology in the human resources planning and management processes. The Health Service Board and the Ministry quickly adopted the use of website-based recruitment and deployment framework where candidates could be deployed from the website and other electronic communication mechanisms. This move is likely going to permanently transform human resources practices and in the medium term, improve efficiencies especially on the turnaround times in the deployment of health professions. The existence of COVID-19 also led to the realisation of the need to decentralise the deployment of cadres to speed up the decisions of deploying cadres from provincial to district levels. Before COVID-19, requests for concurrences would follow a long bureaucratic route from the station via Ministry up to the Health Service Board for approval. However, a new measure saw the revision of handling communications regarding deployment of cadres from stations, a policy directive decentralised deployment of cadres through replacements where institutions could directly request candidates for deployment at the Board by whatever quickest means that is the use of emails. In addition, the Health Service Board saw an increase in the Monitoring and Evaluation Officers' establishment at provinces leading to efficiencies in the deployment of cadres upon posts falling vacant. Additionally, as COVID-19 associated deployments were necessary at Secondary and Tertiary levels, the employer felt the need to increase the autonomy of such specialised institutions in dealing with human resources issues specifically

deployments. As a result, the Health Service Board elevated the reporting framework of the human resources functions at all Central and Provincial health institutions to be able to report at the highest-level issues to do with the deployment of health professionals. With the pressure from the Presidium to report at forums like the National COVID-19 Taskforce, the Board and the Ministry needed robust deployment mechanisms and timeous data on deployment processes at institutions to accurately report at the National level. There is substantive ground to conclude that COVID-19 pressure led to the improved efficiencies on the planning, management, and reporting on deployment of health professionals.

5. Research Implications

It can be noted that the findings add knowledge to the growing body of knowledge on COVID-19 especially on its impact on the deployment of health professionals. The findings are critical to policy as they may be a stepping-stone towards improved crisis deployment strategies in the MoHCC in particular.

6. Conclusion and Recommendations

Recruitment policies of health personnel need to be guided by demand and should not be sanctioned by the Treasury. Treasury needs to support the MoHCC's human resources requests as health personnel require to be valued in the country. This enables the government to maintain a good nurse-patient ratio which relieves pressure on the health workforce leading to better performance. This can be achieved through long term investment in the health department. Long term investment. Building health sector resilience and preparedness to pandemic outbreaks requires persistent and adequate government funding. Short-term emergency planning is very difficult for third world countries that are already struggling with the bread-and-butter issue. It may be difficult to find money to divert from the crisis hence long-term planning may be the solution. Adequate funding enables the Ministry to design and implement an incentive structure that helps to deploy the health workforce. Health responses to disasters like COVID- 19 may never be adequate when funding is to be sourced outside government and there is over-reliance on donors. Adequate financial rewards help reduce brain drain.

Decentralisation and the introduction of information technology are a welcome development and need to be implemented forever in the MoHCC as this forms part of the Ministry's preparedness in disaster management. Centralisation of decision-making retards the Ministry of the much-needed power to quickly make deployment decisions during crisis periods. As the pandemic escalates, governments are to consider temporary redeployment of staff voluntarily in settings foreseeing temporary staff shortages linked to a caseload peak to minimize interruption of essential health services. The Human Resources directorates need to prioritise deployment towards the COVID-19 response personnel especially the deployment of national emergency medical teams. The Ministry may consider redeploying experienced staff from low- to high-burden settings. In the absence of medical expertise locally, MoHCC needs to consider relying on deployment international flows of individual health workers in the COVID-19 response, however, done in compliance with ethical principles to manage international health worker mobility.

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