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Where there is no policy: governing the posting and transfer of primary health care workers in Nigeria

Seye Abimbola[1,2,3]*, Titilope Olanipekun[4], Marta Schaaf[5], Joel Negin[1], Stephen Jan[1,3] and Alexandra L. C. Martiniuk[1,3,6]

[1]*School of Public Health, University of Sydney, New South Wales, Australia*
[2]*National Primary Health Care Development Agency, Abuja, Federal Capital Territory, Nigeria*
[3]*The George Institute for Global Health, Sydney, New South Wales, Australia*
[4]*School of Public Health, University of Texas Health Science Center at Houston, Texas USA*
[5]*Averting Maternal Death and Disability, Mailman School of Public Health, Columbia University, New York, USA*
[6]*Dalla Lana School of Public Health, University of Toronto, Ontario, Canada*

SUMMARY

The posting and transfer of health workers and managers receives little policy and research attention in global health. In Nigeria, there is no national policy on posting and transfer in the health sector. We sought to examine how the posting and transfer of frontline primary health care (PHC) workers is conducted in four states (Lagos, Benue, Nasarawa and Kaduna) across Nigeria, where public sector PHC facilities are usually the only form of formal health care service providers available in many communities. We conducted in-depth interviews with PHC workers and managers, and group discussions with community health committee members. The results revealed three mechanisms by which PHC managers conduct posting and transfer: (1) periodically moving PHC workers around as a routine exercise aimed at enhancing their professional experience and preventing them from being corrupted; (2) as a tool for improving health service delivery by assigning high-performing PHC workers to PHC facilities perceived to be in need, or posting PHC workers nearer their place of residence; and (3) as a response to requests for punishment or favour from PHC workers, political office holders, global health agencies and community health committees. Given that posting and transfer is conducted by discretion, with multiple influences and sometimes competing interests, we identified practices that may lead to unfair treatment and inequities in the distribution of PHC workers. The posting and transfer of PHC workers therefore requires policy measures to codify what is right about existing informal practices and to avert their negative potential. © 2016 The Authors The International Journal of Health Planning and Management Published by John Wiley & Sons Ltd

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*Correspondence to: S. Abimbola, School of Public Health, University of Sydney, Rm 128C, Edward Ford Building A27, New South Wales 2006, Australia. E-mail: seyeabimbola@hotmail.com

INTRODUCTION

The establishment of posting (deployment) and transfer (redeployment) mechanisms that are necessary to ensure fairness to health workers and managers and their equitable distribution across populations has received less policy and research attention, compared with other human resource challenges such as capacity building, performance and retention (Schaaf and Freedman, 2015). This is especially the case in low-income and middle-income countries (LMICs), particularly in settings where health system governance is weak (Roome *et al*., 2014). However, posting and transfer underpins many human resources for health and service delivery challenges. The policies and norms governing posting and transfer in LMIC health systems are sometimes inconsistent with the mission of providing equitable access to health services for all, while ensuring fairness to all health workers and managers concerned (Schaaf and Freedman, 2015). The effect of such 'mission inconsistent' posting and transfer policies includes health system inefficiencies, resulting in relative health worker shortages in rural communities; demotivation of health workers and managers; and inability of policy makers and health managers to develop rational training and recruitment strategies—underlying failures to optimise available human resources for health within a country. In addition, mission inconsistent posting and transfer policies can result in weak accountability relations among health workers, managers and the communities they serve (Schaaf and Freedman, 2015; Sheikh *et al*., 2015).

However, there are no formal national policies in Nigeria to inform posting and transfer within the health sector (FRN, 2006). Nigeria operates a three-tier federal system of government. The national (i.e. federal) government is responsible for providing policies and guidelines governing primary health care (PHC), in addition to oversight and technical support for PHC nationally. However, sub-national governments (i.e. states and local governments) are jointly responsible for providing logistics and human resources for health to implement PHC. While state governments typically recruit PHC personnel to work within a PHC system, the health facilities within which they work are primarily owned and operated by local governments (LGs) (NPHCDA, 2013a). But each state government may have different arrangements regarding which sub-national government takes primary responsibility for PHC, such that the government of some states may take on more responsibility than others for running PHC facilities and distributing PHC workers among them (FMOH, 2004; FRN, 1999; Bonilla-Chacin *et al*., 2010). However, the primary responsibility for PHC is often left to LGs, which are the weakest tier of government (Oyegbite, 1990; Abimbola *et al*., 2014). In the absence of a national policy to inform posting and transfer in the health sector, the decentralisation of PHC governance in Nigeria has the potential to result in different posting and transfer practices across states and LG areas.

In Nigeria, equitable distribution of health workers is worst at the PHC level, although formal health care services in many communities are largely provided through public sector PHC facilities (Bangdiwala *et al*., 2010). The demand and supply mechanisms, which drive if, why, how and where to post and transfer PHC workers may be influenced by the value judgements of health managers, power differentials among health managers and workers, the preference of stakeholders such

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as politicians and community members and the personal aspirations of individual health workers (Schaaf and Freedman, 2015). A national survey conducted in 2005 showed that the attrition of doctors and nurses away from working at the PHC level was much higher compared with secondary care and tertiary care, such that in the public sector, only about 20% of doctors and 30% of nurses worked at the PHC level (Chankova *et al*., 2006). With the exception of community health workers, 90% of whom work at the PHC level (they are trained for 2–3 years to work at the PHC level); PHC workers tend to seek posting or transfer to PHC facilities in urban areas, or leave to work in secondary or tertiary health care facilities, which are usually located in urban communities and are run by better resourced tiers of government (secondary care by state governments; tertiary care by the federal government) such that salaries are higher and more regular (Chankova *et al*., 2006; Abimbola *et al*., 2015).

In addition to the three tiers of government, community health committees provide governance for PHC facilities at the community level. The national health policy is to institutionalise community engagement in PHC. Responsibility for this engagement is delegated to community health committees, with the majority of PHC facilities being linked to a health committee (Abimbola *et al*., 2014; Das Gupta *et al*., 2003; Bonilla-Chacin *et al*., 2010). Established through a participatory approach, these committees (also known as ward or village development committees) are part of the decentralised process of PHC governance in Nigeria. Committee members include 'respectable' community members, such as primary and secondary school head teachers; representatives of traditional, religious, women, youth and health-related occupational groups; and the health worker in charge of the PHC facility. Committees are expected to meet at least once every month (NPHCDA, 2013b). The roles of the committees include identifying the health needs of the community and liaising with other members of the community, government and non-governmental organisations to find solutions. Although they are expected to supervise, monitor and support activities at the PHC facility to which they are linked, there is no specific mention of influence or input to the posting and transfer process among their expected roles and responsibilities (NPHCDA, 2013b).

To inform policies and practices that will promote fairness and equity, it is important to understand the nuances of how posting and transfer occur in different settings. However, there is a paucity of studies on posting and transfer in the health sector. Existing studies and reports document how frequent transfers of health workers in Nepal (Barker *et al*., 2007), India (Datta, 2009) and Kenya (Turan *et al*., 2012) and of health managers in Colombia (Bossert *et al*., 1998) and Pakistan (Collins *et al*., 2000; Jokhio *et al*., 2007) may lead to poor health system performance. Studies have also highlighted some reasons for posting and transfer practices that are not consistent with equity and fairness in the health system, such as effective lobbying to avoid or reverse rural posting by health workers in Nepal (Aitken, 1994). In addition, studies have found that informal payments, family and friendship relationships, ingratiation with managers and political patronage are used to secure favourable posting and transfer to urban areas and communities that provide opportunities for informal income by health workers in Nepal (Aitken, 1994) and Indonesia (Blunt *et al*., 2012) as well as among health managers in India (Wade, 1985) and Pakistan

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(Collins *et al*., 2000). However, these findings tend to be incidental (the studies were focused on something other than posting and transfer) and to be from the perspective of health workers and managers (and not community members). The existing body of evidence therefore does not constitute a sufficient basis for crafting policies and interventions (Schaaf and Freedman, 2015).

Given the range of potential influences on posting and transfer in the health sector, and because health workers are in short supply, it is necessary to understand the details of how and under what circumstances posting and transfer occur in order to craft policies that ensure fairness and equity. Using a qualitative approach, this study examines how, in the absence of formal national policies, the posting and transfer of frontline health workers at the PHC level is conducted in Nigeria. The study includes the perspective of health managers, health workers and community health committee members.

METHODS

Study setting

The study was conducted between November 2014 and January 2015 in four states across Nigeria: one in northern Nigeria (Kaduna), two in central Nigeria (Nasarawa and Benue) and one in southern Nigeria (Lagos). The states were chosen for their geographic spread across Nigeria, potentially encompassing a range of PHC governance arrangements within Nigeria. Each of the four states has an average of about 20 LG areas. Two LG areas were randomly selected in each state, and two communities were purposely selected from each LG area to ensure a broad range of practices and perspectives are represented. In all, there were four participating communities in each state, making a total 16 communities across four states. All the communities included in this study had community health committees. In Nigeria, a minimum of 19 health workers are recommended to staff a standard PHC facility: 1 medical doctor, 4 staff in the nurse-midwife category, 10 community health workers, 1 each of pharmacy and laboratory technician, and 1 each of medical records and environmental officers (NPHCDA, 2013b). Given the shortage of medical doctors, mid-level health workers (in the nurse-midwife and community health workers categories with at least 2–3 years of post-secondary school health care training) undertake tasks typically carried out by medical doctors, as is the trend in other LMICs (GHWA, 2013).

Study participants

The study participants were purposively selected in terms of geographical spread to ensure that participants had the potential to provide rich, relevant and diverse information. We conducted focus group discussions with members of community health committees in each of the 16 selected communities across the four states. In addition, we conducted 40 in-depth interviews: with 25 PHC workers (of which 14 were the officer in charge—the PHC worker, typically the most senior, who oversees each PHC facility) and with 15 PHC managers working at the local (7), state (4) and

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federal (4) tiers of government. Each group discussion involved 8 to 10 participants and lasted about 90 min, while each interview lasted about 60 min. We included as participants only formal and full-time PHC workers involved in direct health care provision.

Data collection and management

We developed semi-structured questions and prompts to explore the practices and perspectives of participants on the posting and transfer of PHC workers, with a focus on the roles of governments, PHC managers, community members and PHC workers. The study instrument probed the reasons behind the posting and transfer decisions, including years of service, health worker performance, punishment, lobbying, financial benefit or inducement, career advancement, working and living conditions, community satisfaction with health workers and health workers satisfaction with the community. The interviews and group discussions were conducted by eight trained researchers in pairs, all of them staff and consultants to the National PHC Development Agency in Nigeria, selected for their ability to speak the local languages of their respective study states. They were briefed on the purpose of this study by author—S. A. Researchers met participants for the first time during the study, but there were prior telephone contacts to schedule data collection. The interviews and group discussions were conducted in offices within health facility premises or an open space nearby. By the time we had conducted 40 interviews and 16 group discussions, participants were no longer presenting new issues, and at this point, researchers agreed that data saturation had been reached. There were no repeat interviews or group discussions. When required, the data were translated to English by the researchers who conducted the interviews and group discussions. The interviews and group discussions were audio-recorded and were subsequently transcribed and transferred to Microsoft Excel to aid analysis.

Data analysis and theoretical framework

Two authors (S. A. and T. O.) read the transcripts independently and used bottom-up coding to categorise issues related to the posting and transfer of PHC workers. This was carried out according to a theoretical framework, which defines PHC governance at three levels: (1) constitutional governance (how federal, state and LG actions and decisions influence posting and transfer); (2) collective governance (how the actions and decisions of communities influence posting and transfer); and (3) operational governance (how interactions between PHC workers and individual community members influence posting and transfer. In this framework, each level of governance influences the other two and vice versa). This multi-level framework is described in greater detail elsewhere (Abimbola *et al*., 2014). Thus, we conducted directed content data analysis by coding and categorising patterns in the data based on an existing framework (Hsieh and Shannon, 2005). Disagreements in coding and discrepancies in interpretation were discussed and decided by consensus. Phrases or quotes that most accurately expressed or illustrated the categories under each theme were then identified.

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Ethics

Ethics approval for this study was provided by the National Health Research Ethics Committee of Nigeria. Participation in the study was entirely voluntary and based upon the participant signing a written informed consent form. In line with the terms of consent to which participants agreed, the data for this study are not publicly available, and all participants have been de-identified, by removing potentially identifying information such as name, gender, cadre, community and LG of participants.

FINDINGS

Based on the interviews and discussions, we found that in general, PHC workers are hired by the state government and posted to LG areas, but subsequently, their posting and transfer between PHC facilities is conducted by PHC managers at the LG level. There are however variations in practice across the four states in the extent of oversight and involvement of PHC managers at the state level in posting and transfer. In Lagos and Kaduna, state PHC managers do exercise oversight on posting and transfer. There is an ongoing transition to greater state responsibility (from a more decentralised system) for PHC in Nasarawa, which is leading to state oversight for posting and transfer. In Benue, the state government is not involved in posting and transfer of PHC workers. State government oversight on posting and transfer is associated with the existence of state PHC boards, which were formed in response to policy advocacy (since 2010) by the federal government to streamline PHC governance such that states instead of LGs take primary responsibility for PHC service delivery (NPHCDA, 2013a).

Three themes emerged to characterise the mechanisms through which PHC managers conduct posting and transfer in the absence of a formal policy: (1) as a general routine exercise; (2) as a specific tool for improving health service delivery; and (3) as a response to the requests for punishment or favour.

Posting and Transfer as Routine Exercise

Participants of all categories highlighted that health workers are routinely posted and transferred at the discretion of PHC managers at the state and LG levels. In the words of a state PHC manager in Kaduna: ‘we have a management committee that sits and discusses posting… and the local governments also have it at their level, where they discuss and decide on posting and transfer.’ One federal PHC manager in Nasarawa, referring to ongoing reforms in the state, said: ‘previously, posting and transfer was the sole responsibility of the local government, but with the coming of the PHC board, they now have a say too.’ In the majority of instances, however, LG PHC managers make the routine posting and transfer decisions with neither much openness nor predictability, and this is the case across all four states. Thus, expectations of how long a PHC worker spends in a post before routine transfer vary from one state or LG area to another. For some PHC managers, health workers ought to spend a minimum of 2 years in a PHC facility, (e.g. ‘PHC workers must spend two years in a place before they move’—state PHC manager in Lagos) while some others put it at

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a maximum of 5 years (e.g. 'there is no law stating the number of years, but ideally should be five years at maximum'—LG PHC manager in Kaduna). Preferences on how long they should stay in a PHC facility also vary among PHC workers between a minimum of 2 years (e.g. 'a health worker should be allowed to spend two to three years before transfer'—PHC worker in Nasarawa) and a maximum of 5 years (e.g. 'someone that has spent up to five years in a PHC facility should be changed'—PHC worker in Nasarawa).

Participants also highlighted challenges with routine posting and transfer. The secrecy of the process often prevents community members from making input to the posting and transfer of PHC workers. For example, when asked who decides how long a PHC worker spends in a PHC facility, a community health committee member in Benue said: 'we don't really have an idea. The people in a better position to answer are health workers or managers. Things that have to do with the local government staff, they take them to be so secret.' Responding to the same prompt, a community health committee member in Lagos said: 'we will not be informed when they will be posted here and we won't know when they will be transferred out again.' The same health committee member subsequently added that 'we will like to be involved so that when the people come they will work harder and dance to our own tune.' Notably, by not involving communities in routine posting and transfer decisions, an opportunity to make PHC workers accountable to the community is missing. The PHC workers themselves are also not aware. In the words of one in Kaduna, 'the local government just gives the person a letter', and in Lagos, a community health committee member said 'they don't involve us in such [posting and transfer] decisions. Even the staff involved will not know. They will just be served the letter.' Thus, the notice of routine posting and transfer typically comes unpredictably, without pre-information or counselling: a disrespectful practice, not only to health workers but also to community members.

However, while some communities want to be able to keep high-performing PHC workers longer than PHC managers tend to allow, PHC managers conduct routine transfers to maximise health worker exposure and learning and to prevent them from becoming too entrenched. One health committee member in Nasarawa said 'I would advise they leave workers that are very active for longer period like five to seven years.' Another in Lagos complained that 'the interval is too short between postings. Our last officer in charge had lots of fascinating programs for our facility, but was transferred too soon'. On the other hand, PHC managers conduct routine transfers in the expectation that PHC workers will gain more experience by moving from one community to another. In Nasarawa, a state PHC manager said 'no staff is kept longer than three years in a facility, to make them change location and gain experience', and a state PHC manager in Kaduna said 'when some staff overstay in a facility, they become unproductive.' Some PHC workers justified routine transfers; one in Kaduna said they are 'for more experience – so that we would know how well we delivered our services in our previous facility.' Further, PHC managers conduct routine transfers to prevent PHC workers from becoming entrenched in a community. Referring to this tendency, a state PHC manager in Nasarawa said once entrenched, 'a lot of these PHC workers don't want to leave where they are because of the extra money they make from selling drugs and consulting privately.' This

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rationale was supported by some health committee members, as one in Lagos said: 'when health workers stay in one place for a long period, they think they are in charge and they act like they are alpha and omega.' Engaging in illegitimate profit-making activities may however be the result of weak supervision, which as participants highlighted, also allow for absenteeism and overcharging of patients; all issues routine posting and transfer of PHC workers only may not be sufficient to prevent.

Posting and Transfer to Improve Services

Some state and LG PHC managers also effect some posting and transfer to improve PHC services—PHC managers may specifically target experienced and high-performing staff for transfer to communities perceived to be in need of such health workers. In one example of such reasoning, a LG PHC manager in Benue describes the impact a single PHC worker can have on a community: 'when you post a health worker who is ineffective, a clinic will go down in patronage. So we will think of someone who can go and activate that place, and before you know it the clinic is up again.' In another example, a state PHC manager in Lagos said 'when there is a need to send someone to a place, if there is a place that has so much patronage, we look for somebody who can withstand the crowd, who can manage it maturely.' In Kaduna, a LG PHC manager gave an example of using posting and transfer as a tool to achieve improved performance: 'I go round facilities, and I discovered one officer in charge was active. That's why I recommended her to be posted to this failing facility, and the previous officer in charge, I took her to a smaller facility to manage.' In agreement with this practice, a PHC worker in Nasarawa said 'active staff should be posted to busy facilities and if the staff is very active and he knows his work well, they could even send him to a facility that is not working.' However, given there is a finite number of such competent PHC workers, the downside of this practice is that competent PHC workers may become unevenly distributed, and some PHC facilities may thereby be deprived of quality services. In addition, while in some cases, transfer to a smaller facility may be the way to deal with a poorly performing health worker; in other cases, the health worker may require support.

Some participants expect that targeted posting and transfer can be used to address imbalances in the rural–urban distribution of PHC workers. One federal PHC manager in Nasarawa said: 'staff should be redistributed to rural communities which I notice have only one or two health workers while most of the urban centres have 10 to 12 health workers whereas the need is more in rural communities.' On the contrary, some other participants are more concerned about perceived needs that rural communities have less need for PHC workers. For example, a PHC worker in Nasarawa said: 'they [PHC managers] should look at the facilities that are busy and post staff that are active there, because facilities that are situated in rural areas, there's little work there.' Part of the rationale for this is that having too much down time leads to absenteeism, as explained by a PHC worker in a rural community: 'when we come in and there is no one coming, nobody is responding, then you start feeling bored. You are reluctant to come to work because there is nothing to do.' In a previous study in Nigeria, a strategy used in communities to reduce absenteeism of

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PHC workers is for health committees to work towards improved uptake of services (Abimbola *et al*., 2015). However, it may also be the case that the low uptake of services in some communities is as a result of having absentee PHC workers in a community may also lead to low patronage. Posting and transfer as an intervention may not be sufficient to address absenteeism or rural–urban imbalance in distribution and might even worsen it if health workers are systematically posted to urban communities because of to low service uptake in rural areas.

Notably, a distinct posting and transfer intervention was instituted by the state PHC board in Lagos to reduce absenteeism among PHC workers—an arrangement in which PHC workers are to be posted near their place of residence. In the words of a LG PHC manager in Lagos: 'after three years, a PHC worker is entitled to move but it doesn't really happen because the state PHC board has agreed people should work close to where they live in order to ensure better service delivery.' The PHC manager justified this by saying 'Imagine if I live close by. Even if they call me at 11 pm, I will come because I live close by. Not when you will spend five hours on the road.' However, this arrangement does not cover all PHC workers in the state; a state PHC manager gave a sense of the extent: 'we make sure that 80% of the health workers work near where they live, and for the other 20% we still make sure that they are as close as possible to where they live.' This popular arrangement among PHC workers in Lagos is also a popular proposal elsewhere. In Kaduna, for example, a PHC worker said that in making posting and transfer decisions, 'they [PHC managers] should consider the distance where you stay and where the facility is located' and a community health committee member in Lagos said 'where staff live should be considered as it affects the efficiency of health workers – that is the complaint of most of the health workers.' But the policy has its downsides. In the words of a state PHC manager in Lagos: 'sometimes you find many [PHC] workers concentrated at a particular area. For instance, there are so many living in Ikorodu [a peri-urban settlement in Lagos] and they become concentrated in a PHC facility.' Thus, posting and transfer according to health workers' preference does not mean that the distribution of health workers will be consistent with the needs of the health system.

Posting and Transfer in Response to Requests

Participants highlighted how different health system actors (PHC workers, political office holders, global health agencies and community health committees) influence the posting and transfer of PHC workers, whether for good or bad, by making requests to PHC managers. This lobbying can be conducted directly by the health care worker in question or, to even greater effect, via a politically powerful intermediary. These interventions are often part of an effort to reverse rural posting or transfer. For example, one LG PHC manager in Benue spoke about lobbying through politicians: 'some because their husband is in Otukpo [an urban settlement in Benue], or because they have political connection, they believe that they are not meant to work in the village.' This quote also illustrates the important gender dimension to posting and transfer requests. In the words of a PHC worker in Kaduna: 'If they post a woman to a rural community, the husband may not allow her and they may decide to find

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their way to go back to an urban area through the people they know.' Indeed, PHC managers are also more open to requests from women, as one LG PHC manager in Lagos implies: 'a health worker posted far from where they live may have a family; a man can easily move and you know most of us [PHC workers] are women. If the request is genuine, we will sort it out.' In one such instance in Nasarawa, a PHC worker said: 'I made a complaint about my sick husband when I was transferred because they posted me to a community with bad road access. They asked me to put it in writing, which I did and it was approved.' Indeed, in addition to gender, health was another reason about which PHC managers expressed openness to requests from PHC workers. For example, a PHC manager in Lagos said: 'except on health grounds, health workers do not have the right to start asking to be transferred to a place. And if they request it, an investigation will be conducted to know why the health worker should be transferred.'

In Benue and Nasarawa, local non-governmental organizations (NGOs) implementing human immunodeficiency virus (HIV) services in selected PHC facilities conduct in-service training of health workers at the PHC level and exert influence on posting and transfer. In one instance of political influence in Nasarawa, a state PHC manager said 'the state commissioner for health directs that some people who are trained in a particular role should be moved from facilities that may not offer those services, such as PMTCT [Prevention of Mother-to-Child HIV Transmission].' Likewise, a LG PHC manager in Benue said 'recently certain NGOs working with us went as far as stipulating that "this capacity building we are giving to this particular individual, we don't want any transfer so that it won't affect our programme." ' The PHC manager added that 'in a situation like this, the management keeps to this rule.' In addition, PHC workers successfully request the reversal of transfers away from facilities offering HIV services. PHC workers also lobby for inclusion in the training opportunities that will qualify them for transfer to the facilities offering HIV services. In the words of a LG PHC manager in Benue: 'when it is time for training, they come and ask to be posted to the PHC facility'. The possibility of earning additional income in such health facilities may explain such requests. A LG PHC manager in Benue posts health workers to such facilities to reward high performance: 'for the ones that are hardworking I recommend they should be posted to where they run PMTCT, to the programme clinic, where they are given stipends to encourage them.' However, while privileging the HIV projects of global health agencies may help achieve disease control outcomes, the downside is the possibility of concentrating well-trained and high-performing staff in such facilities, thereby depriving other PHC facilities.

In contrast, PHC managers are more open to community requests. There are three forms of such request; communities ask to post PHC workers to a facility in need, to reverse the transfer of a high-performing PHC worker and to post a PHC worker elsewhere because of poor performance viz. lateness, absenteeism, overcharging, seeing patients privately and disrespectful care. To request that a PHC worker be posted to their community, the health committee sends a letter to LG PHC managers or seeks an audience with them to make a verbal request. This is a common experience among community health committee members, and in many instances, they are successful. For example, one community health committee member in Lagos said

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'we have verbally recommended that staff be posted to our facility, and staff were posted down here.'

While many of the communities in this study have the experience of reversing the transfer of a PHC worker, the PHC managers expressed a general reluctance to accede to such requests from community health committees. And while communities tend to accept the decision of PHC managers, others resort to lobbying harder through their traditional leaders, or through politicians, who then instruct LG PHC managers to grant the requests. The reason PHC managers refuse requests to reverse transfers include concerns that 'it would cause a psychological bond between the health worker and the community' (PHC worker in Nasarawa), because 'there is no one that is indispensable and there is no one that cannot be worked with' (LG PHC manager in Lagos), because 'the health worker has to move on; no one can stay in one place' (LG PHC manager in Lagos) or because 'we should know what is best for them' (LG PHC manager in Benue). Thus, in response to requests to reverse transfers, PHC managers typically set out to convince community health committees to give the new PHC worker a try: a proposition they often accept without regret. One LG PHC manager in Benue said: 'when they are trying to reject [a replacement], it is our responsibility then to talk with them heart to heart in order for them to reason with us, and before you know it they will accept.' This was confirmed by community health committees; one member in Benue said the committee: 'receives complaints once a new officer in charge is posted because of their methods and ideas. But when the community members get used to the new health worker over time, such complaints don't come again.'

On the other hand, PHC managers respond differently when communities make specific complaints about health workers whether new or old. Health worker behaviour leading to community complaints includes lateness, absenteeism, overcharging, seeing patients privately and disrespectful care. In such instances, community members (patients, clients and their parents or spouses) first complain to the community health committee; the committee admonishes the PHC worker in question, and they may also ask the officer in charge to do so, when the officer in charge is not the offending PHC worker. If there is no change in behaviour, the community health committee complains to the LG PHC manager (verbally or in writing), who then investigates the allegation. Once offence is confirmed, a LG PHC manager reprimands the offending PHC worker. If the issue persists, the PHC worker is transferred elsewhere, sometimes 'to a far place' or to the LG headquarter for close monitoring, especially when the offence is prolonged absenteeism, for which PHC managers may also discontinue salary payments until the health worker shows up. However, because these reports can be effective, there is a perception in some communities that health workers conceal the lapses of one another from the community. One health committee member in Lagos said: 'they will not allow us to know, because it may escalate. So they solve problems of performance among themselves.' Thus, complaints arising from fellow health workers tend to stop at the desk of the officer in charge, except when the issue persists or it negatively affects other health workers such as persistent lateness to take over duty during shift work. In one instance, in Nasarawa, a state PHC manager said: 'someone kept giving the excuse that she was going for social functions, and other staff kept complaining to the officer in

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charge.' This continued until the matter was reported to the PHC manager who 'warned that if she doesn't heed she will be transferred to another facility where the officer in charge handles such issues with every seriousness.'

In reporting complaints, community health committees link up with the proximate LG PHC managers rather than the more distant state and federal PHC managers—except during the latter's occasional supervisory visits. But in many instances, even LG PHC managers are not readily accessible for community complaints. In the words of one LG PHC manager in Kaduna: 'communities don't have access to me, so they can't report to me directly.' In such a situation, community health committees only get to complain to LG PHC managers during their supervisory visits. In the meantime, complaints about PHC workers are directed to the officers in charge. However, in many communities, the health committee members are not aware they are in a position to complain about health workers to PHC managers. In one such community in Lagos, a health committee member said: 'we have not been given that opportunity, so we don't know how it is done.'

DISCUSSION

This study shows that even in the absence of a formal national policy, there are common mechanisms by which state and LG PHC managers conduct the posting and transfer of PHC workers in Nigeria: as a routine exercise, as a strategy to improve service delivery, and in response to the requests of health system actors. However, each mechanism may be conducted in ways that are inconsistent with providing equitable access to health services across populations while being fair to all PHC workers in a state or LG area. For example, the expectation that PHC workers would gain more experience or would be prevented from being corrupt is perhaps neither a sufficient nor necessary justification for periodically moving them from one community to another (i.e. routine transfer), unpredictably, unannounced, and without their or community input and may have adverse consequences on morale. Likewise, posting and transfer as a strategy to improve services can exacerbate existing imbalances in the rural–urban distribution of health workers. For example, systematically moving high-performing health workers from rural PHC facilities to busier ones (usually in larger and urban communities) may worsen health outcomes in the communities from which they are transferred. Similarly, moving health workers nearer where they live may concentrate workers in the more desirable sub-urban or urban communities. High-performing PHC workers tend to be transferred to where service uptake is unexpectedly low or have recently plummeted, while the underperforming PHC worker is transferred elsewhere deprived of the opportunity to improve and potentially subjecting people in undesirable areas to poor quality of care.

However, our findings suggest that PHC managers use their discretion on posting and transfer as a lever to promote accountability—in the form of motivation and discipline of PHC workers—and to promote performance and quality. This is perhaps because the other levers for achieving these ends have not been readily available to PHC managers. Personnel management is fragmented—while PHC workers are hired by state governments, they are primarily overseen by LGs. To discipline a

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PHC worker, PHC managers require the approval of committees spread across local and state governments, and the main criterion for staff promotion is the number of years of experience and not performance. These leave PHC managers with little else but posting and transfer to influence the performance of PHC workers (Bonilla-Chacin *et al*., 2010). The ongoing move to streamline and centralise PHC governance at the state government level however provides opportunities for improvements as LG PHC managers will function within state PHC boards, thus reducing existing fragmentations (NPHCDA, 2013a). Even then, responsibility for posting and transfer of PHC workers is perhaps better left primarily for the LG PHC managers who are in a better position to respond to community requests and to have more information about the communities due to their proximity. But their decisions may need to be reviewed periodically by state PHC managers to ensure they are not partial, unfair or corrupt. Posting and transfer in response to community requests holds significant promise for fostering accountability between PHC workers and communities. But complaints will need to be investigated to ensure they are not made on discriminatory or false grounds or due to misunderstanding of situations or events.

Some of our findings are in keeping with the limited literature on posting and transfer in the health sector. For example, there are documented concerns on the negative impact of frequent transfers on overall health systems in India (Datta, 2009) and Pakistan (Collins *et al*., 2000; Jokhio *et al*., 2008), on health sector reform in Colombia (Bossert *et al*., 1998) and Mali (Maiga *et al*., 2003), and on global health agency-funded projects in Nepal (Barker *et al*., 2007) and Kenya (Turan *et al*., 2012). But in addition, our study shows the influence of global health agencies (exerted directly or on their behalf by governments), on reversing transfers from the PHC facilities implementing their projects in Benue and Nasarawa—two of the states with the highest HIV prevalence in Nigeria, with many HIV projects, funded by global health agencies and implemented through local NGOs in selected PHC facilities (Bashorun *et al*., 2014). As in Nigeria, a previous study in Indonesia showed that health workers lobby to be posted to donor-supported health facilities (Blunt *et al*., 2012), but unlike in our study, by paying informal fees. In the same study in Indonesia (Blunt *et al*., 2012), and another in Nepal (Aitken, 1994), health workers also lobby and pay to obtain posts in urban communities. Our findings suggest that the skew in rural–urban distribution of PHC workers in Nigeria may arise from such lobbying, and also that political patronage is partly responsible, as previously shown in Nepal (Aitken, 1994), Pakistan (Collins *et al*., 2000) and Indonesia (Blunt *et al*., 2012). In addition, our finding that married women tend to lobby their way out of rural posts is in keeping with that of a previous study in Nigeria (Uzondu *et al*., 2015). Further, our finding that health workers sometimes get punitive transfers to the LG headquarters for closer monitoring corresponds with findings in Nepal, where it is recognised as ironic, given that a transfer to the LG headquarters (typically in urban areas) is often desirable (Aitken, 1994).

In colonial India, frequent transfers were used by the British to limit opportunities for corruption, and the practice of routine transfer of PHC workers in Nigeria, also a former colony of Britain, may at least in part be due to a colonial norm that has persisted (de Zwart, 2000). Indeed, the practice persists in India in spite of evidence that instead of limiting corruption, routine transfers may create opportunities for

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corruption, especially as health workers may not be constrained by social ties, and resolving a case of corruption is not feasible because of brief stay in a community (de Zwart, 2000). While our study did not uncover any instances of payments to obtain desirable posts or transfers, participants described cases of overcharging of patients and illegitimate private consultations by PHC workers. However, studies have shown that 'informal' economic activities of PHC workers (i.e. earning incomes outside official duties and earnings) may be a response to irregular or insufficient salary (McPake *et al*., 1999; Das Gupta *et al*., 2003; Bonilla-Chacin *et al*., 2010). Such informal economic activities say more about failure of government provision and oversight than about health worker corruption (Abimbola *et al*., 2014). Likewise, issues such as inadequate or lack of supervision, accommodation, financial incentives, social amenities and community engagement in rural areas may continue to lead to absenteeism even if PHC workers are only temporarily posted to work in rural communities on rotation. Thus, addressing broader government failure may be important in tackling the concerns for which posting, and transfer is often conceived of as a remedy in Nigeria.

Even though participants freely discussed instances of corrupt practices by PHC workers, there were no references to instances of buying posts and transfers from PHC managers. This indicates one of two alternative possibilities. Either such practices exist, but were concealed by participants, or and perhaps more likely, that buying posts and transfers is rare or does not exist at the PHC level in Nigeria. This may be because the salary of PHC workers is lower, and payment more irregular compared with secondary and tertiary care where the status of health workers is higher (Abimbola *et al*., 2015). Hence, PHC workers with the means to procure posts and transfers may instead do so to work at higher levels of care. A limitation of this study therefore is that we did not consider pathways of exit from PHC into secondary or tertiary care. Another limitation is that given that all participating communities in this study had a health committee, we were not able to examine posting and transfer in communities without a health committee, where posting and transfer in response to community request may function differently. In addition, it is possible that bias was introduced into our study in the process of translation or because our data were based on self-reports. We however sought to triangulate the data as findings as we obtained data from different categories of PHC stakeholders in each jurisdiction. Beyond the governance perspective adopted in this study, our findings suggest other potential dimensions to posting and transfer, such as gender, corruption, patronage and other nuances of social, political and economic context. Future studies may examine posting and transfer from these perspectives. Given that posting and transfer is an issue with potentially consequential health policy responses (Sheikh *et al*., 2015), such studies should be conducted across LMICs: not only of health workers but also of health managers, not only at the PHC level but also in secondary and tertiary care.

In making posting and transfer decisions, PHC managers at headquarters may not have as much information as community members and health workers who are out in the field. This indicates a need to incorporate bottom-up input into government planning. Given the role of community health committees in holding PHC workers accountable, efforts aimed at improving posting and transfer systems should include ensuring that health committees have designated tools and channels for making requests for and reports on health workers to PHC managers. A policy on posting

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and transfer of PHC workers could require that health committees have regular meetings with officers in charge of PHC facilities, and state and LG PHC managers to discuss the state of PHC facilities and the conduct of PHC workers. These meetings could serve as a forum for investigating charges brought by the community and, based on this, making recommendations to PHC managers for appropriate action. The policy on posting and transfer should also clearly spell out how and under what circumstances transfers can be used as either a punitive or an incentive measure or in response to the influence of politicians and global health agencies. The policy will also recognise the input of PHC workers, taking into account their comfort, with rules that are clear and sufficiently flexible to address the circumstances, needs and preferences of PHC workers in different contexts. Implementing these policy measures will however require broader governance reforms, including on how PHC managers can incentivise performance and quality beyond the use of posting and transfer.

CONCLUSION

In summary, this study reveals the rationale behind the different mechanisms adopted for posting and transfer of PHC workers in Nigeria, even in the absence of a formal policy. But there are also practices that may lead to inequitable distribution of health workers or which may not be fair to all PHC workers within a jurisdiction. It may therefore be more appropriate to have a uniform and flexible policy measures based on local evidence to apply across the board for posting and transfer of PHC workers. But even such a policy may not be implemented in ways that will ensure equity and fairness without broader governance reforms to ensure optimal provision and oversight of PHC services. In addition, PHC managers require levers with which to promote performance and quality with other channels for discipline and motivation beyond posting and transfer. However, given that posting and transfer is conducted by discretion, with multiple and sometimes competing interests, and in a context of sub-optimal levels and inequitable distribution of the health workforce, posting and transfer challenges will likely continue to underpin service delivery challenges in LMICs. But even with commensurate levels of the health workforce, posting and transfer issues may persist, given the personal aspirations, preferences, value judgements and issues of power involved. It is therefore important that considerations for posting and transfer continue to be a research and policy priority in the health sector.

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