

Influence of Externally Funded Programs on Human Resource for Health in health service delivery

A case study of two districts in Kenya

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Abbreviations / Acronyms

CDC	Centre for Disease Control
CDF	Constituency Development Fund
CF	Clinton Foundation
CHWs	Community Health Workers
CO	Clinical Officer
CORPS	Community Own Resource Persons
DASCO	District Aids and STI coordinator
DH	District Hospital
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
EFPs	Externally Funded Programmes
FBO	Faith Based Organizations
GAVI	Global Accelerated Vaccines Initiative
GF	Global Fund
GOK	Government of Kenya
GP	General Practitioner
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HBC	Home Based Care
HC	Health care
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HWs	Health Workers
I/C	In Charge
ICROSS	International Community for Relief of Starvation and Suffering
IMC	International Medical Corpse
JPWF	Joint Programme of Working and Funding
KEPH	Kenya Essential Package for Health
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical supply Agency
LATF	Local Authority Transfer Funds
LVCT	Liverpool Voluntary Counselling and Testing centre.
MCH	Mother and Child Health
MD	Medical Doctor
MOH	Ministry of Health
NACC	National Aids Control Council
NARESA	Network of Aids Researchers in East and Central Africa
NASCOP	National Aids and STD Control programme
NGO	Non-governmental Organization
NHSSP	National Health Sector Strategic Plan
PMCT	Prevention of Mother to Child Transmission
PHO	Public Health Officer
PHT	Public health technician
PSC	Patient Support Centre

SDH

Sub-District Hospital

TB

Tuberculosis

VCT

Voluntary Counselling and Testing

Acknowledgement

This study is the result of a joint work between Wemos, Consumer Information Network (CIN) of Kenya and Centre for Health Science & Social Research (CHESSORE) of Zambia in collaboration with Great Lakes University of Kisumu (GLUK).

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Executive Summary

Background: Human Resources for Health (HRH) constitute one of the key components of any national health system, and many developing countries face serious HRH constraints. The overall shortage of health workers in developing countries has several dimensions. Not only is there an absolute shortage of staff, the available workforce is often ill-distributed within the system and attrition rates are high as a result of brain drain and HIV/AIDS. Staff motivation and morale is reported to be low. Anecdotal evidence suggests that there is severe competition for personnel and staff time between various health programmes and between public and private providers. Such competition is reinforced by the vertical nature of various funding mechanisms supported by bilateral donors, international NGOs and global initiatives. In Kenya it is widely acknowledged that there is a human resources for health crisis. Several interventions addressing issues surrounding human resources for health are included in HNSSP II, AOP II, draft HRH Strategy and Joint Support Program.

Study objective: To analyse in what way HRH recruitment, deployment and retention at the district level are influenced by externally funded programmes.

Methodology: The study was a multiple case study, with 2 districts: Suba and Bondo serving as cases, since they are the managerial entities of which the management team (DHMT) is responsible for planning, finance, HRM, the coordination of various health programmes and district health in general. Broadly two types of tools were used to collect data including inventory forms, focus group discussion (FGDs) and key informant interviews (KIIs) while analysis was done both manually for qualitative data and through excel computer package for quantitative data.

Results: The findings of this study show that the two districts are characterized by insufficient staffing in relation to outdated establishments set in 1990. Except for a big deployment of nurses, in general staff deployment and attrition were balanced. While most doctors left their post voluntarily other cadres were mostly transferred, retired or died. Policy restrictions and lack of funds make it impossible for DHMT to recruit more staff. Coping strategies of DHMT include collaborations and partnerships with government agencies and EFPs to increase staff, equip facilities and improve housing and road infrastructure.

An inventory of EFPs shows that EFPs in Kenya differ in 1) their funding modality: through MoH or not through MoH but through NGOs and 2) their HR strategy: 2a) using existing public health staff and/or recruiting their own staff and 2b) limit staff tasks to HIV/Aids or let them implement overall general government tasks.

The biggest positive influence on HRH is caused by EFPs that recruit additional HR. Of these EFPs Clinton Foundation channelled the funds through MoH and recruited 104 additional HR for general tasks. The other EFPs channel their funds through NGOs that recruits staff to do HIV/Aids activities. Other positive influences include availability of drugs, improvement of living conditions, increase of equipment, locum activities and capacity building by training of staff. Negative influences were created by EFPs that entirely depended on MoH staff, like GFATM, increasing their non-clinical administrative duties and

making them work longer longer. Some EFPs were actively engaged in directly sourcing staff from the public health sector offering better packages compared to the government package which resulted in competition and possibly explaining high attrition rate among doctors.

Conclusion: Good policy intentions for HRH improvement cannot be achieved without consistency and commitment and actions of key players in the district: DHMT and EFPs. DHMT does not have the mandate and the capacity to apply a common approach to interact with EFP in order to achieve optimal positive influence on HRH. EFPs apply various HR strategies. The best strategy entails channelling funds through DHMT in order to recruit additional human resources to deliver general ministry of health tasks as done by Clinton Foundation.

Recommendations: It is recommended that steps be taken by MoH to strengthen DHMT's capacity to undertake HRH planning, implementation, monitoring and evaluation of HRH after which DHMT is able to develop operational HRH plans that include EFP support for HRH. EFPs and other development partners to increase its HRH support for general health service delivery activities based on these HRH plans.

1. Introduction

1.1. Background

It is widely recognised that health systems in many low-income countries are not strong enough to enable the efficient delivery of good quality health services that are accessible to the most vulnerable people in society. In view of the huge amount of external resources that are currently being made available with a view to achieving the MDGs, there is a widespread call for sustainable health systems development in addition to the ongoing programmes that focus on specific diseases or vulnerable groups.

Human resources for health (HRH) constitute one of the key components of any national health system, and many developing countries face serious HRH constraints. The overall shortage of health workers in developing countries has several dimensions. Not only is there an absolute shortage of staff, the available workforce is often ill-distributed within the system and attrition rates are high as a result of brain drain and HIV/AIDS. Staff motivation and morale is reported to be low.

There is little systematic insight into the actual human resource constraints at the operational level of hospitals, health centres and other institutions that produce services. While information on numbers of staff may be available or (relatively) easy to obtain, there is little insight into their actual deployment and the way health staff spend their time on the delivery of services and administrative duties. Anecdotal evidence suggests that there is severe competition for personnel and staff time between various health programmes and between public and private providers. Such competition is reinforced by the vertical nature of various funding mechanisms supported by bilateral donors, international NGOs and global initiatives (GI; or global health partnerships, GHP), such as the Global Fund for Aids, TB and Malaria (GFTAM) and others. This has intensified the call for increased harmonisation of donors, including the ongoing global initiatives, and their alignment with national policies, so as to take maximum advantage of their potential and minimise any disruptive effects on system-wide planning and management of HRH across the sector.

Wemos wishes to make a contribution towards sustainable health systems development in developing countries by redressing domestic and external (donor) support for health systems strengthening, including HRH; and more in particular by supporting partner organisations in selected countries in their advocacy for adequate and equitable health budgets and improved human resource allocation and utilisation.

In contributing to sustainable health systems, Cordaid builds capacity of local organisations. It considers HRH strengthening as an essential part of its work with 'southern' partner organisations. It puts a special emphasis on building the institutional capacity of these organisations and learning from best practices in development cooperation. Cordaid supports piloting of innovative strategies for enhanced HRH.

¹ Anecdotal evidence suggests that private providers funded by global initiatives are able to offer higher salaries and/or better working conditions. This may undermine government efforts to retain health staff for the public sector. Competition for staff can be expected to increase as a result of scaling-up aid flows through global initiatives.

The results of the study, which was carried out in Bondo and Suba districts in Kenya, will be used for advocacy purposes: to put pressure on local and national governments in developing countries to increase their budgets for health personnel and improve labour conditions. At the international level the results will be used to convince policy makers in donor countries to better address the problem of the shortage of health workers, by allowing donor funds to be spent on recurrent costs, making long-term commitments and aligning the large number of different initiatives.

The results will also be helpful in strengthening the capacity of local communities in the districts where the study takes place, to demand their right to the highest attainable standard of health. The data collected will provide insight into expenditures on human resources for health and in the way in which global health initiatives and international donor policies affect health systems.

1.2. Statement of the problem

Many low-income countries, particularly in Sub-Saharan Africa, struggle to strengthen their human resource capacity in the health sector, in particular at health facility level, to ensure the provision of quality health services that are accessible to those who need them.

While several studies have been conducted that concentrate on health systems constraints at the national level, little is known about the operational level, i.e. the health districts, where local priorities are set and operational plans are being made, and the various health facilities that render services (hospitals, health centres; irrespective whether they are publicly or privately owned).

The effects of external agencies, including global initiatives such as GFATM, GAVI, PEPFAR, the Clinton Foundation and the Gates Foundation, on local service delivery and in particular the way human resources are being utilised is quite unknown. Such information is necessary so as to address possible anomalies and ensure that human resources for health are used in the most efficient and effective manner.

The core problem that is at the heart of the study is defined as “inadequacy and inequitable distribution of human resources for the delivery of essential health services at the district level”.

Three main factors are believed to directly influence this problem: inadequacies in staff recruitment, in deployment and in retention.

The next three diagrams display the various factors that possibly contribute to each of these three types of inadequacies. They display internal influences, such as inadequate human management skills of the DHMT, as well as external influences, such as the presence of externally funded programs and parallel programs.

Problem analysis diagram

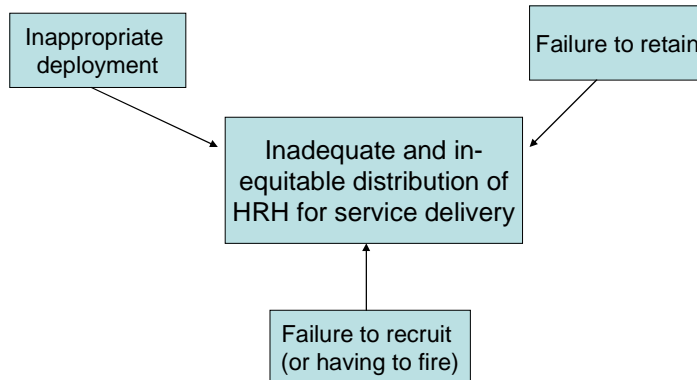


Figure 1: Problem analysis diagram

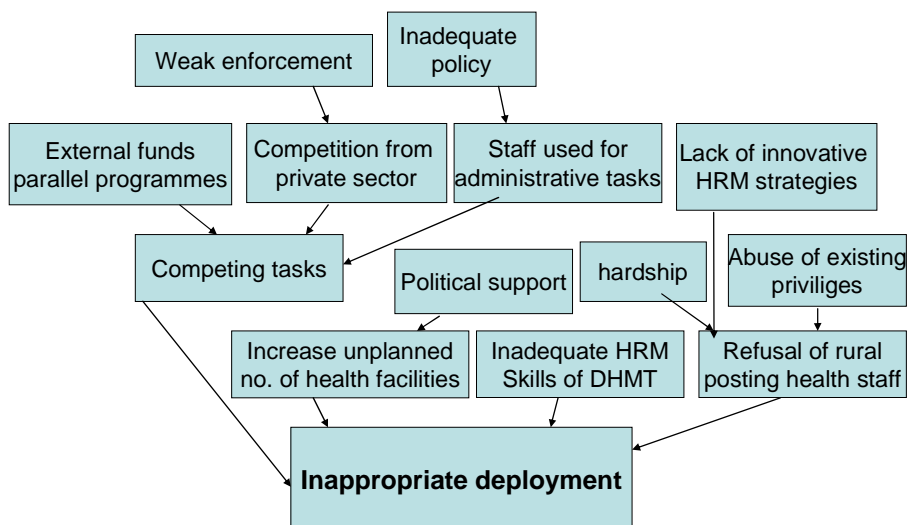


Figure 2: Problem analysis diagram: Inappropriate deployment

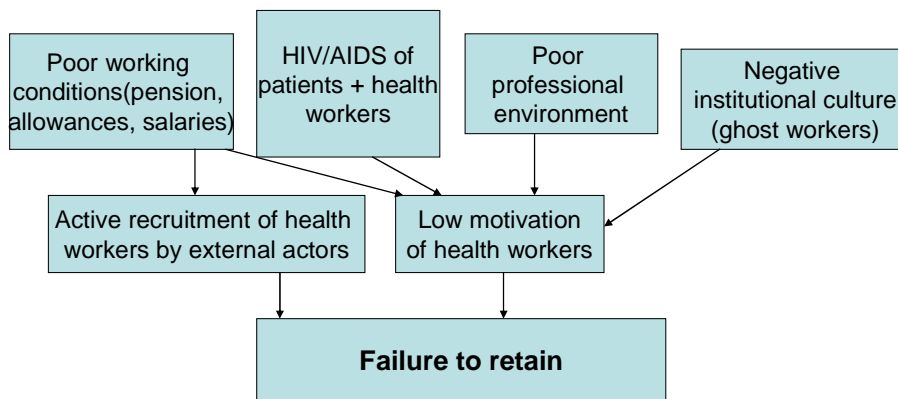


Figure 3: Problem analysis diagram: Failure to retain

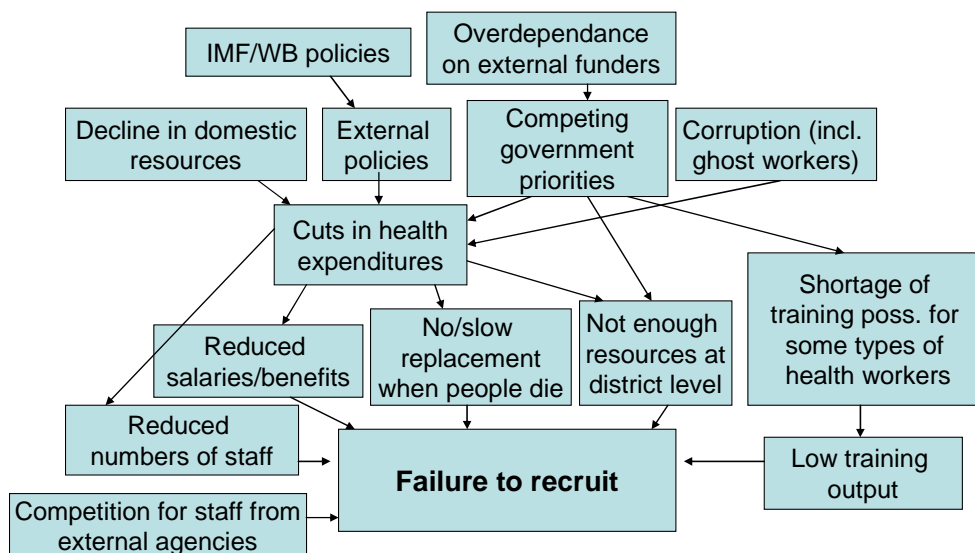


Figure 4: Problem analysis diagram: Failure to recruit

1.3. General literature review

At the heart of each and every health system, the workforce is central to advancing health. Healthcare workers are the lifeblood of health care systems. They need a living wage, good support and on-going training especially those in isolated and under-resourced areas. There is ample evidence that worker numbers and quality are positively associated with immunization coverage, outreach of primary care, and infant, child and maternal survival. The level of experience of doctors and the density of their distribution have been shown to correlate with positive outcomes in chronic ailments. Workers themselves best initiate cutting-edge quality improvements of health care because they are in unique position of identifying opportunities for innovation. In health systems, workers function as gatekeepers and navigators for the effective or wasteful application of all other

resources such as drugs, vaccines and supplies. Human resources for health are recognized as an essential component for overcoming diseases and ensuring global health.

The World Health Report 2006, working together for health, recognized the centrality of the health workforce for the effective operation of country health systems and outlined proposals to tackle a global shortage of 4.3 million health workers. The World Health Report 2006 demonstrates that a minimum of 2.3 health workers per 1000 population is needed to meet the health related MDGs. There is increasing evidence that this shortage is interfering with efforts to achieve international development goals, including those contained in the Millennium Declaration and those of WHO's priority programmes. One enormous factor is that many countries' health systems are not functioning and although they shoulder the highest disease burden, they have the fewest health workers per population.

Human resources for health and health systems in developing countries have been under funded for decades due to harsh economic policies like structural adjustment. The situation has been exacerbated by conflict, the HIV pandemic, weak institutional capacity and the failure of donors to invest in recurrent expenditures like staff salaries. This chronic under-investment has led to collapsing health systems, appalling and unsafe working conditions for health professionals and unfair distribution of health professionals between rich and poor countries.

The shortage of qualified staff in Africa has been aggravated by the increasing emigration of health workers to a number of developed countries. Countries like Ghana have more doctors working overseas (60%) than in their country. In Zimbabwe, only 360 physicians out of the 1200 trained in the 1990s remained in their country. These health professionals are supporting the healthcare delivery and effectiveness of the developed countries. The developed countries in response to their own staff shortages have actively drained highly skilled health professionals without re-investing in the health systems of the source countries especially those in Africa. "Kenya's public health system is short of 5000 nurses yet 6000 nurses are looking for a job in the developed countries." Mr. Edwin Macharia, Director Rural initiative- HIV/AIDS initiative, Clinton foundation.

According to the results of a workshop organised by Africa Recruit together with the commonwealth secretariat and the commonwealth Business Council, in 2006, Africa must triple its number of health workers in order to attain the MDGs. An extra one million health workers need to be recruited trained and effectively supported with resources and safe working conditions. Although African countries suffer 24 per cent of the global burden of disease, they have less than three percent of the world's health workers and account for less than one per cent of the global health expenditure.

The health workforce crisis in developing countries derives principally from inadequate educational opportunities for health workers and a lack of relevance of their training to community health care practice. Additional contributing factors include: inadequate compensation and working conditions, the deteriorating health of the workforce in many developing countries, urban/rural and workforce imbalance, and migration of the workforce from developing to developed countries.

² World Health Organization, 2006: **Working together for health**, The world Health Report.

³ Mobilizing the African Diaspora healthcare professionals for capacity building in Africa.

⁴ Millennium Development Goals

Human resources for healthcare provision have been neglected for decades by governments, donors, international organizations and development policy-makers. The donors and partners are not yet ensuring that available resources are spent on national priorities to meet the needs of the most vulnerable: too often the priorities are set globally with no involvement of the most vulnerable populations. Health sector reforms have not yet ensured that adequate resources, management and decision-making powers are decentralized and accountability mechanisms are weak or non-existent. Such issues have made providing healthcare an enormous challenge for most health workers.

The Poverty Reduction Growth Facility (PRGF) agreement signed with IMF has often been cited as another major barrier to increasing national investments in human resources for health. The IMF supports countries to maintain fiscal stability, at times encouraging them to cap or cut civil expenditure and social spending. Economic policies like structural adjustment have encouraged developing countries to maintain fiscal stability by increasing privatization of nationally owned enterprises, devaluing national currencies and reducing social spending. As a consequence, services promoting human development, this includes health, have been the ones that have faced dramatic cuts. In Kenya, 50% of the nursing posts are vacant and yet a third of the trained nurses are unemployed. The IMF promotes short-term reforms that only focus on public expenditure reduction without evaluating the impact of these measures on poverty reduction and without considering the different macro-economic alternatives.

The WHO definition of health workers is, "people primarily engaged in actions with the intent of enhancing health". They are in health enterprises and their primary role is to improve health and they include doctors, dentists, pharmacists, pharmaceutical technologists, clinical officers, public health officers and public health technicians. According to the World Health Report 2006, health workers are unevenly distributed. Countries with the lowest need have the biggest number of health workers while those with greater burden of disease do with a much smaller workforce a situation that we must change. Staff inequities also exist within countries with rural postings being the hardest to fill in. Doctors, nurses and midwives tend to move from rural to urban areas to secure better working conditions, salaries and schools for their children. The internal migration has also been amplified in Africa by the drain of qualified staff from public services to the private sector. The private for profit sector offers better salaries and working conditions including drug supplies and equipment.

1.4. Policy context Kenya

Key highlights of the HRH Strategic Plan, 2006/07 – 2009/10 concerning HR problem, recruitment, deployment, challenges and opportunities and next steps include the following:

1.4.1. Scale of the HR problem

- MOH Staffing data for 2006: overall staff establishment of 44,813, of which 35,627 (79%) posts are filled.

⁵ Gbary AH and Sambo L G 2006, 'Current focus on African human resources in healthcare', Intervention at the conference mobilising the African Diaspora Healthcare professionals for capacity building in Africa, 21st March 2006, London.

⁶ Volqvartz J 2005, 'The brain Drain', the Guardian, 11th March

⁷ World Health Organization.

- It is difficult to estimate the current total number of health staff across the whole health sector (civil service, private, NGO). The number of registered medical personnel provides some indication of the size of the sector; in 2003 the total was 60,599.
- Anecdotal evidence suggests that there is a large number of unemployed trained health personnel in Kenya, though there is little hard data to substantiate this. But it is known that there are large numbers of people applying for a small number of jobs. For example, in 2005 there were 2,226 applications for 435 ECN III positions and 919 applications for 55 Laboratory Technologist positions. Hence Kenya is different from other countries in SSA, in the sense that sufficient numbers of staff are being trained (at least for certain cadres), but the problem is that only few of them are absorbed into the health system through formal govt employment.
- The faith based organisations (FBOs) indicate that they are facing challenges in recruiting and retaining adequate numbers of staff. They report that they are losing many of their staff to the MoH, attracted by better training and career opportunities. (NHSSP II 2005–2010)
- Generally there is a reasonably even distribution of staff across the provinces. The main exceptions are the relatively low number of doctors to population in Nyanza and Western Provinces and the high number in Nairobi. There are several factors contributing to staffing imbalances; individual preference related to working and living conditions; incentives (including allowances), and weak deployment procedures. No detailed analysis of attraction and retention factors has been conducted. Data on distribution within districts is not available, though it is likely that staff to population ratios are lower in the more rural districts. The NHSSP II acknowledges that there are great disparities between provinces in terms of Human Resource for Health (HRH) resources and quality of service provision. It plans to shift resources from relatively well served areas to areas of extreme poverty (poverty mapping) like North Eastern Province, Nyanza Province and the dry (and poor) northern parts of the country.
- There are currently no agreed staffing norms for the Ministry of Health. However, norms for staffing the KEPH have now been developed (though not yet approved). A total of approximately 427,000 staff will be required (inclusive of CORPs); the figure is 105,735 excluding the CORPs (overall deficit of 391,373 staffs).

1.4.2. Recruitment

- A recruitment freeze has been in place since 1998 and only allows for recruitment to fill vacated posts. The verification study report (MOH, 2006) suggests that the recruitment freeze is an attempt to reduce the health sector wage bill, which according to the Public Expenditure Review Reports stands at 52% of the recurrent health budget. However, if funds are available from other sources health workers can be recruited and put on time-limited contracts.
- For example in recent months, the MoH, with funding from the Global Fund, PEPFAR, Clinton Foundation, has recruited 1,428 health workers, comprising mainly registered and enrolled nurses (800), laboratory technologists and technicians (70) and clinical officers (100). All have been appointed on three year contracts and the majority are aged between 48 and 53 years . Those appointed through Clinton Foundation funding will be absorbed into the government on completion of the contract. According to the MoH all of the 7,633 health workers who applied for these posts were from outside the public sector; they were unemployed or from the private/NGO sub-sectors. These data support the claims that increasing numbers of health workers are being attracted into the public sector from the private sub-sector and that there are significant numbers of health workers unemployed.
- The recruitment of staff to fill vacant posts and/or meet additional requirements is dependent on the availability of funds (PE ceilings) and the number of approved posts (establishment). Any request for recruiting staff must be approved by DPM and funds should be released by Treasury. The current number of MOH established posts is 44,813 (this excludes non-public service

providers), and the total number of MOH staff required to deliver the KEPH (excluding CHWs and non-public service providers) is approximately 35,000, giving a total staff requirement of 79,813, however the current number of funded posts is only 35,627. Whilst there is no official recruitment freeze and the MOF is being more flexible with the funding of PEs for social sector ministries, there are still tight controls on the PE budget.

1.4.3. Deployment

- The plan to upgrade the 13,000 government-enrolled nurses is under implementation.
- No mention of any influence of externally funded programmes on staff deployment.

1.4.4. Challenges and opportunities

- Global initiatives (and MDGs) are mentioned as a contextual factor, not as a particular challenge (like decentralization) or opportunity (SWAp, KEPH).

1.4.5. Key areas for intervention

- Strategic HR planning, management and development
- Coordination across the sector involving employers other than MoH
- Delivering KEPH
- Improving systems, e.g. more effective and appropriate use of existing staff, redeployment, incentives, more effective recruitment process
- Performance management
- Linking HRH planning to wider planning and review process of SWAp and NHSSP II
- Improving information systems.

1.4.6. Overall aim and expected main outcomes of the HRH strategy

Aim: ensure adequate numbers of equitably distributed and appropriately skilled and motivated health workers.

Expected outcomes:

- Appropriate numbers and types of health workers in post
- Increased numbers of equitably distributed staff
- Improved institutional and health worker performance
- Improved human resource development
- Strengthened HR planning and management
- No mention of the role of global initiatives in any of the strategies proposed or as any implementation issue to achieve the above outcomes.

1.5. Definition of terms

In this study the following terms are used according to the definition described.

Private provider:

Any provider of health services other than the government (including NGOs, faith-based/church-based organizations and for profit institutions)

Externally funded health programmes (EFP):

Programmes that receive their funding from external sources, i.e. not from the Government. Various types of externally funded programmes (or projects) may be distinguished, depending on:

1. Their funding modality: with funds either flowing through the government or outside government through NGOs
2. Their human resource strategy: 2a) concerning personnel recruitment: using existing staff and/or recruiting their own staff and 2b) concerning personnel tasks: limit staff tasks to HIV/Aids or let them implement overall general government tasks.

2. Study objectives and research questions

2.1. General objective

To analyze in what way HRH recruitment, deployment and retention at the district level are influenced by external funding and to what extent this is in line with national and district policies and strategies.

2.2. Specific objectives

1. To establish the trend in HRH recruitment, deployment and retention at the district level in the past five years (2002-2006), and the reasons for attrition.
2. To assess whether HRH have been distributed according to needs within the district and identify the reasons for any gaps.
3. To determine the proportion of funding by central government, donors and district's own resources towards staff recruitment, deployment and retention at the district level in the past five years.
4. To identify and document the coping strategies employed by DHMT in recruiting, deploying and retaining HRH.
5. To document the extent to which NGO and parallel programmes at district level have influenced the recruitment, deployment and retention of HRH over the past five years.
6. To determine the influence of external funding agencies on the productivity of HRH.
7. To provide suggestions for the optimal use of external funds in improving HRH utilization.

2.3. Research questions

Specific objective 1: To establish the trend in HRH recruitment, deployment and retention at the district level in the past five years (2002-2006), and the reasons for attrition.

1. Take stock of all health interventions and actors active in the district.
2. Data on recruitment of different cadres for the public sector, by year.
3. Data on recruitment of different cadres by private health institutions, by year.
4. Deployment: the number of different cadres deployed in various public sector health facilities.
5. Deployment: the number of different cadres in various health facilities in the private sector.
6. Attrition: the number of health workers who have died, transferred, migrated, retired or resigned, for the district as a whole, by type of cadre, by year and by type of facility.
7. According to key informants (and records, if any), what are the reasons for attrition through resignation, transfers, migration?

Specific objective 2: To assess whether HRH has been distributed according to needs within the district and identify reasons for any gaps.

1. According to formal government standards how many HRH for the different cadres are supposed to be there (staff establishment) and how many are actually there by year (make a distinction between staff on government payroll and those funded externally)?
2. How does the DHMT establish staff needs (what criteria does it use)? (add question do you take into account staff paid by other funders)?
3. What are the reasons for the gaps for the different cadres between the DHMT figures and the actual situation? (information to be collected: national government, DHMT, some bigger health facilities)?

Specific objective 3: To determine the proportion of funding by GRZ/GOK, donors and district's own resources towards staff recruitment, deployment and retention at the district level in the past five years.

1. What is the total funding for health received by the district and what are the sources of funding?
2. (Take stock of all external funding sources and their financial contributions)
3. What are the sources of funding specifically for HRH recruitment, deployment, retention in the past five years?
4. What proportion of funding for HRH comes from the sources mentioned above (government, donors, districts themselves)?
5. What have been the trends in funding HR in the district in the last five years?
6. What are the salary levels, allowances and top-ups that are being paid by externally funded programmes; for which cadres and how do these compare with government salaries and allowances?

Specific objective 4: To identify and document the coping strategies employed by DHMT in recruiting, deploying and retaining HRH.

Recruitment:

1. What mechanisms has the DHMT used to recruit staff?
2. What are the past experiences of DHMT in recruiting HRH?
3. What factors hinder or facilitate recruitment of HR and how are districts coping?

Deployment:

1. What challenges does the district face in deploying staff?
2. What has been the past experience of DHMT in deploying staff?
3. What effects do parallel programmes have on deployment of HR in this district? How have the health authorities coped in the last five years?

Retention:

1. What has DHMT done to retain HRH staff and what has been the experience? (Successful and unsuccessful?)
2. What factors have constrained staff retention?

Specific objective 5: To document the extent to which NGO and parallel programmes at district level have influenced the recruitment, deployment and retention of HRH over the past five years.

1. Which of the stakeholders (see obj. 3) are and/or have been involved over the past five years in the recruitment of HRH and how? (variables: direct employment, indirect employment, training, staff benefits,)
2. Which of these stakeholders are and/or have been involved over the past five years in the deployment of HRH and how? (variables: motivation, HRM skills, competing tasks, etc)
3. Which of these stakeholders help or hinder to retain HRH; and how? (variables: motivation, active recruitment)
4. Do health professionals and managers experience any influence of external funding agencies on district HRH (taking into account the observed shifts in staff deployment)? How do they appreciate this influence?
5. How could external funding be made more beneficial to address the local HRH constraints, according to local stakeholders?

Specific objective 6: To determine the influence of external funding agencies on the productivity of HRH.

1. What kinds of tasks are being carried out by different types of health workers and is this in line with district priorities? (refer to district health plan)
2. Have there been any shifts in staff time allocation due to various competing tasks over the past five years?
3. Are there any activities that have been neglected due to concentration on externally funded activities (how much time do health workers spend on these health activities?) (variables: type of activities, time, type of staff)

3. Methodology

3.1. Study type and study populations

The study was a multiple case study, with districts serving as cases, since they are the managerial entities of which the management team (DHMT) is responsible for planning, finance, human resource management, the coordination of various health programmes and district health in general.

Data was collected about the current situation in the districts concerned, as well as retrospectively for the past five years. The study was descriptive – describing trends over time and health workers' personal experiences – and analytic in nature, analysing causes and effects of the observed trends, and perceived cause-effect relationships. Both quantitative and qualitative data were collected.

3.2. Data collections techniques and instruments

Data collection techniques used comprised:

- Use of already existing information (from staff records and financial accounts)
- Key Informant Interviews (KII) with District Medical Officers (DMOs), Health Facility in charges, Human Resource Managers, Program/Projects coordinators and administrators
- Focus Group Discussions (FGDs) with the DHMT and nurses

The annual district health plans were used to retrieve existing information.

Table 1 and 2 include the data collection forms that were administered in each district.

Table 1: Inventory forms used

	Title	Administered with	Total No.
1	Inventory of private health providers	DHMT	1
2	Inventory of externally funded programmes	DHMT	1
3	Staff movements in and out of the district	DHMT – HR officer	1
4	Staff attrition from the public sector	DHMT – HR officer	1
5	Health staff at private facilities	Individual private providers	2
6	Financial expenditure on HRH through DHMT, by source and by year	DHMT – accountant	1
7	Financial expenditure on HRH by individual private providers	Individual private providers	2
8	Financial expenditure on HRH by externally funded programmes	Coordinators of externally funded programmes	6
9	Information on salaries and allowances – compilation sheet	Various sources	

Table 2: Interview schedules were administered:

	Title	Administered with	Total No.
A	Individual interviews with DMO (& DHMB chairperson)	DMO / DDH	2
B	Group interview with DHMT members	DHMT	2
C	Individual interviews with coordinators of externally funded programmes	Coordinators of programmes identified through Form 2	10
D	Individual interview with officer in charge of Govt HF (& chairperson of HF board)	Selected health facilities	4
E	Individual interview with officer in charge of private providers	Selected health facilities	2
F	Focus Group Discussion with health staff at hospitals that are involved in externally funded programmes and health staff working outside EFPs	Nurses, midwives, ...	4

Data collection instruments were pre-tested during a workshop in Zambia, in which a research protocol was developed (in May 2007). Interview schedules A, D and F were pre-tested through mock interviews. Interview schedules D and F were tested through trial interviews with health staff at two health centres in Lusaka district. After evaluating the pre-test in the field, amendments were made.

3.3. Sample size

In Kenya, two districts were selected for the study: Bondo and Suba districts. Both are in Nyanza province. Both districts have a number of externally funded programmes that are active in the health sector. Table 3 shows the details about the two districts.

Table 3: District statistics

District	Bondo	Suba
Population	275,411	184,646
Total # of health facilities	33	24
Hospitals	2	2
Health centres	7	10
Dispensaries	24	12
Total # of technical health workers	170	117
Medical doctors	2	3
Clinical officers	22	10
Nurses and midwives	117	72
Other cadres	29	32

Source: MoH Bondo , 2007 and MoH Suba 2007

3.3.1. Sampling techniques

Sampling within the districts was done at two levels:

- Purposively, 4 government health facilities were included in the study in which externally funded programs were present and all cadres were deployed. These included a district hospital and a sub-district hospital in each of the two study districts. Two private health facilities (1 faith based and 1 community based private for profit) were also purposely selected in the study, being the only facilities with potential to influence public staff movement by level of their operation and cadre of staff they hire.
- All health workers working within the selected health facilities were included as potential participants in the study. For the recruitment of participants in focus group discussion, convenience sampling was applied: those health workers present on the day that the FGD was conducted were invited to participate.

3.4. Data processing and analysis

All data collected were cleaned and coded for completeness. Following this, data processing was done in two stages:

- Quantitative data processing was done using excel computer package to establish trends in HRH budgets, recruitment and attrition as well as the reasons for attrition. This analysis was further used during the phase two data collection stage.
- Qualitative data was processed manually by themes, through data compilation sheets and categorization of concepts and theories done to derive trends for establishing conclusions.
- Preliminary findings were discussed at a workshop and critiqued in order to define final conclusions arising from the results.

3.5. Ethical consideration

Ethical clearance for the study was obtained from the Ministry of Science and Technology in Kenya.

3.6. Limitations of the study

The study had some limitations, including;

- Inadequate data retrieval due to inadequacies in DHMT information system
- Inadequate responses from coordinators of externally funded programmes at the district level due to the structural design of such programs. The design of the tools assumed that the coordinators of EFPs would have all information regarding the funding and program implementation plans, which turned out not to be the case.

4. Research Findings

4.1. Inventory of externally funded programs, private for profit and private not for profit providers at the district level

In both Bondo and Suba districts, only few faith based organisations (FBOs) and private for profit providers are present. In Bondo the faith based services include 2 dispensaries and 2 health centres which are all located in remote parts of the district (Rarieda and Nyang'oma divisions). Three medical staff (2 nurses and 1 CO) are working in the only private facility in Bondo at the district headquarter. In Suba, there are 6 FBOs (3 health centres and 3 dispensaries), employing between 2 to 4 nurses only and none among the private for profit category of facilities.

Externally funded programs in the health sector that are present both in Bondo and Suba districts can be broadly classified into two categories; first, programs administered through MoH and secondly, those that are not administered through MoH. In both Districts, programs administered through MoH include Clinton Foundation (CF) and Global Fund Aids TB and Malaria (GFATM). Externally funded programs not working through MoH but through NGOs in Bondo include ICROSS, Mildmay, Plan, NARESA and CDC. While in Suba district FACES, IMC and World Vision (WV) are administered outside the MoH.

These EFPs apply different human resources strategies:

- 1) concerning personnel recruitment: using existing staff and/ or recruiting their own staff and
- 2) concerning personnel tasks: limit staff tasks to HIV/Aids activities or let them implement overall general government tasks.

Table 4 shows the breakdown in funding modality and human resource strategy.

Table 4: EFPs in Bondo and Suba district.

	Additional funding Human Resources		GoK Human resources/ Allowances	
	Mostly HIV/Aids	Government tasks	Mostly HIV/Aids	Government tasks
Through MoH	GFATM (7) IMC (4)	CF (104)	GFATM	
Not through MoH but through NGOs	CDC (4) FACES (40) IMC (46) MildMay ICROSS	NARESA (5)	FACES CDC IMC	PLAN WV

* (no.) = Number of human resources funded by EFP

Table 5 and 6 give detailed information on the externally funded programs operating in the districts.

Table 5: externally funded programs and NGOs in Bondo

EFP	Focus	Funding	HR strategy
GFATM	- HIV/Aids (Tx, VCT) in some facilities at district & sub district hospital - Malaria (prevention) in all health facilities	Donors	HIV/Aids: -Recruitment of 1 DASCO -Training of MoH staff Malaria/TB: -Secondment of PHO for 30% -Recruitment of 7 PHTs
CDC	Mostly research HIV/Aids	USAID	- 4 CDC staff recruited in health facility to carry out CDC program, separate from health facility services - Giving allowance to MoH staff that is lower than allowance given to CDC staff - Training of CDC staff (DTC)
Naresa Network of AIDS Researchers in East and Southern Africa	Reproductive Health	USAID	- Recruitment 5 staff (3 nurses, 2 peer counsellors) for secondment to MCH department - Higher salary than MoH - Seminar allowance - 1 year contract - Training for all (PMTCT, VCT)
Mildmay	Home based care	PEPFAR USAID	- Own staff to manage ART and HBC activities
ICROSS International Community for Relief of Starvation & Suffering	Home based care	USAID	- Own staff to manage field food security and HBC activities
Plan International	Outreach and child sponsorship (75% direct individual sponsorships to children, 25% general grant)	Plan	- Giving allowances to selective MoH staff
Clinton Foundation	Primarily HIV/Aids, but staff is able to carry out all health service delivery tasks	Danida	- Recruitment of 50 nurses - Same salary and scale as MoH

Table 6: externally funded programs and NGOs in Suba

Program/ NGO	Focus	Funding	HR strategy
GFATM	- HIV/Aids (Tx, VCT) in some facilities at district and subdistrict hospital - Malaria (prevention) All health facilities	GFATM Through MoH	- 1 MoH staff seconded to coordinate HIV/Aids, malaria and TB activities
FACES 2006	Patient Support Services (PSS) Mobile ART clinics in District hospital and sub district hospital and in all health centres	USAID	- Recruitment of staff by advertisement not encouraging MoH staff - 40 staff (including COs, lab, social workers, nurses) - FACES staff works together with MoH staff in PSS - Providing locum opportunity (800/day) - Supervision, mentoring and training for their staff and locum - 6 months training to CHWs - 1 year renewable contract slightly higher than MoH salary - Clear promotion possibilities - Coordinator of FACES is member of DHMT
IMC 1994	Dispensaries, private clinics VCT, PMTCT, mobile clinics, monthly reporting (just recently started TB and malaria activities)	USAID	- Recruitment of staff, in total 46 (mostly VCT counsellors) - Secondment of IMC staff to Sub district hospital (1 lab, 2 VCT, 1 MCH nurse) - Salaries higher than MoH and annual increment plus secondary benefits - Working through MoH staff especially in mobile clinics - Outreach allowance is similar to MoH staff (800/day)
World Vision	Food and income security and HIV/AIDS	World Vision	- Using MoH staff -Low lunch allowance
Clinton Foundation	HIV/Aids but staff is able to carry out all health service delivery tasks	Danida	- Recruitment of 54 health workers (45 nurses and 9 COs)

4.2. Staff distribution patterns

In both districts, the filled positions to total establishment proportion for the nurses is just about double while all other cadres have less than the expected proportions against total establishments. The proportion of doctors compared to expected proportion of total establishment was worst affected (2% compared to expected 4%). Rural facilities have even far worse proportions. For

instance, in Bondo District, some facilities such as Mageta Dispensary which is on an island had to do without a technical staff, only to be managed by Community Health Workers. Table 7 gives the tabulation of staff cadres by proportional comparison between the actual and establishment by districts.

Table 7: Proportion of total current filled positions vs expected proportion of total establishment

	Bondo District		Suba District	
	Expected prop. of total establishment	Prop. of actual HRH filled	Expected prop. of total establishment	Prop. on actual HRH filled
Doctors	11 (4%)	3 (2%)	11 (5%)	3 (3%)
Clinical officers	25 (10%)	13 (8%)	58 (25%)	10 (9%)
Nurses & midwives	108 (42%)	96 (61%)	87 (38%)	72 (62%)
Other tech. staff	60 (23%)	29 (18%)	73 (32%)	32 (27%)
Casuals	54 (21%)	16 (10%)	No data	

4.3. HRH funding levels

From 2007/2008 the Ministry of Health has extended the bottom up planning & budgeting approach that was started in 2005/2006 on a pilot basis in selected districts, to all districts in the country. Bondo and Suba adopted the approach in 2007/08. Before then planning and budgeting was a top down process with not much involvement of DHMTs. But even under the new approach, information on salaries is largely unknown to the DHMT as wages continue to be handled and transferred by the central level. Hence, in both districts the DMOs remarked that salaries and/or other staff benefits had not changed during the past five years.

Currently, human resource planning components include capacity building and recruitment of casual workers (dubbed 'casuals'; not including technical staff). The payment for casual staff is covered by cost-sharing revenues, of which 75% is retained by the facility for its maintenance/improvement and for wages of casual workers, while 25% is remitted to the provincial level headquarter.

Annual budget allocations and disbursement of Ministry of Health for Bondo and Suba are shown in figure 5. The trend shows a peak in 2006/2007, which can largely be explained by Global Fund contribution.

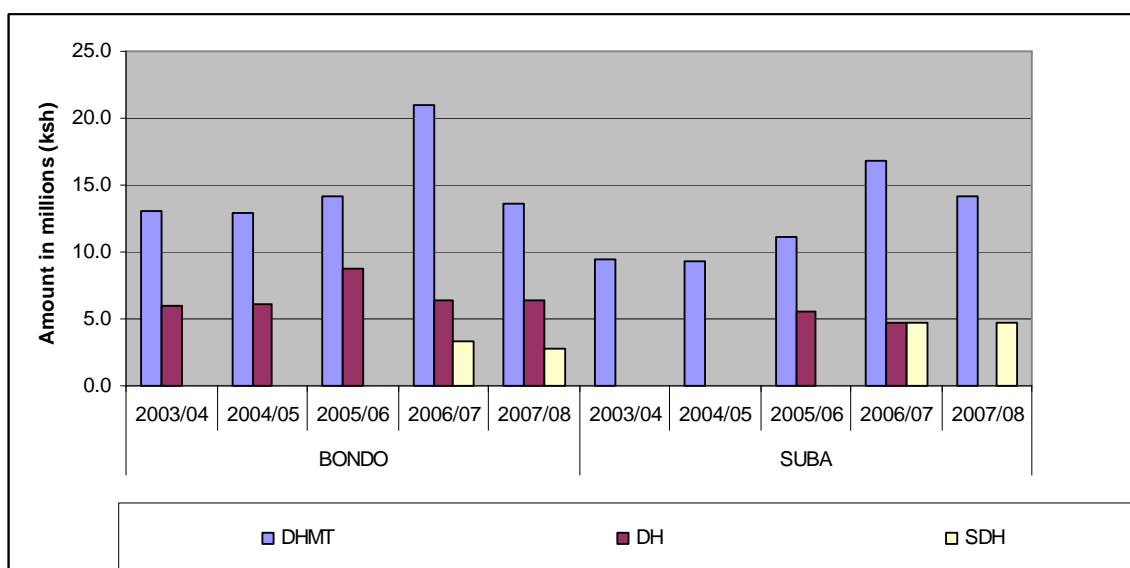


Figure 5: Total district health funding (MoH disbursements plus income from cost-sharing; including global fund, excluding other external funding)

Comparison between annual budget allocations of Ministry of Health and financial figures derived from district record 2006/2007 shows a big discrepancy; for instance MoH budget allocation per district is higher than budget allocation obtained from the districts. This means that either some costs expended for the districts directly by MoH are not captured by the district reporting system or the information system is just not accurate.

At both levels, there is no information on the share of HRH funding which made it impossible to show the trend in funding.

4.4. Trends in HRH recruitment and deployment over the past 5 years

Figure 6 shows the trend in the percentage of staff deployment for various cadres compared to the formal staff establishment from 2003 to 2007 in Bondo District. Figures for Suba district could not be obtained and therefore the trend could not be established. During this period staffing establishment levels decided by central government have not changed: they are still based on 1990 figures, which were set according to type of facility and the catchment population. It is to be noted that since 1990 no corrections have ever been made for population growth (or for changes in task descriptions of specific cadres, following changes in disease patterns or new technologies that have become available).

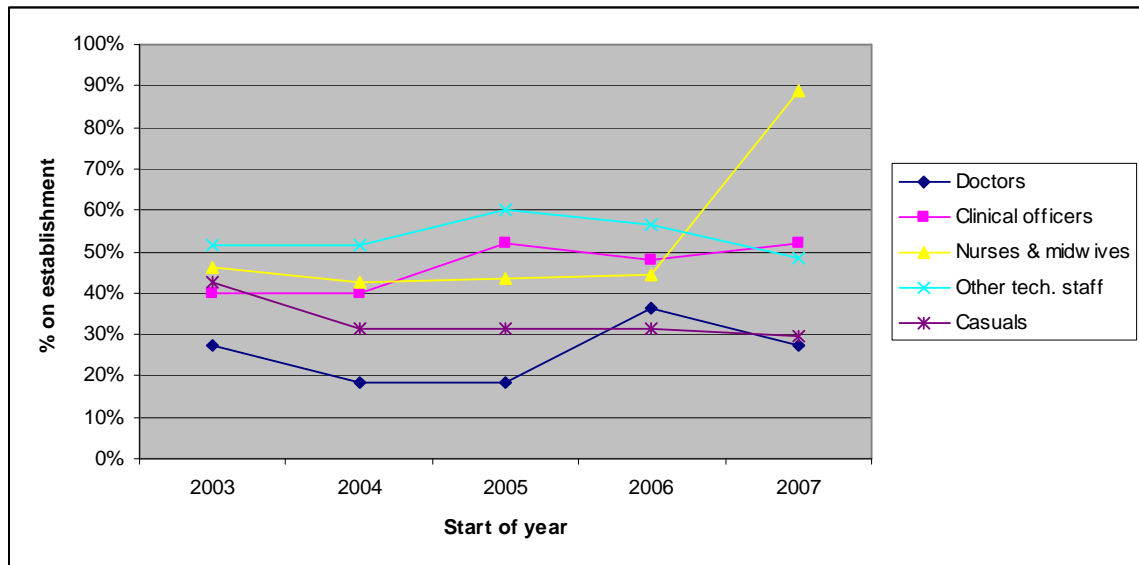
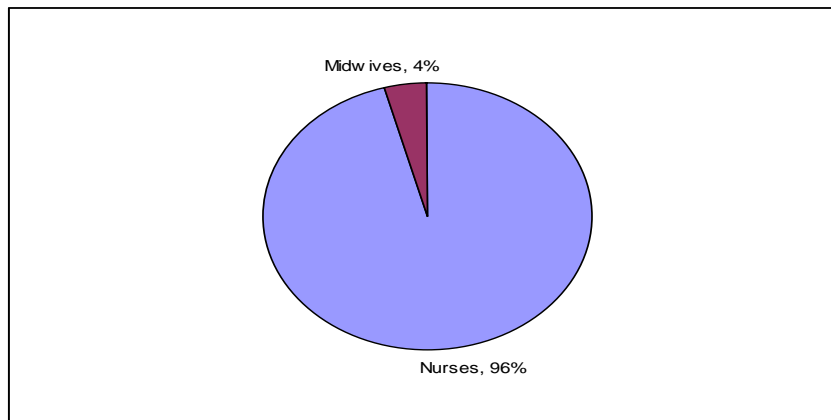


Figure 6: Bondo district staffing trends compared to establishment

Between 2003-2007 all cadres (doctors, clinical officers, nurses & midwives, other technical staff including environmentalists, dentists and pharmacists) remained insufficient. Doctors are mostly affected, with only 18% to 36% of the established positions filled: only 2 doctors were covering the whole district in 2004 and 2005. Clinical officers' positions filled ranged between 40% to 52%.



During 2006, the number of nurses and midwives doubled, increasing from 48 to 96 and leading to 89% of established posts filled. Nurses make up the biggest 46 (96%) part of that year's increase in new entrants as indicated in figure 7.

Figure 7: Proportion increase of nurses and midwives by each cadre

Overall, during 2003-2007 of all cadres, staff has both been deployed and left their posts. For instance, 2 additional doctors have been deployed to Bondo district during the last five years, in 2005. Against this addition, there was resignation of 2 doctors, one in 2003 and the other in 2006. Among the clinical officers, an addition of 4 and 3 joined during 2004 and 2006 respectively, while the district lost 4, one each in 2004 and 2005 and another 2 in 2006. Over the five year period, a total of 55 nurses were deployed in the district with 48 of them being deployed in 2006, while during the same period the district lost 13 nurses. In the same period the district received an addition of 9

midwives and lost 5. Against 11 other technical staff that came during the five year period, 13 left. Information on staff that came in during the five year period for Suba district could not be obtained.

Figure 8 shows the reasons why health staff in Suba and Bondo left their posts. Most doctors left voluntarily, while the other cadres (clinical officers, nurses and midwives and other technical staff) were transferred, retired or died. In Suba district, however, clinical officers, nurses and midwives and other technical staff (pharmacists) were also affected by voluntary resignation.

Table 8: Reasons for staff attrition in Bondo and Suba Districts

District	BONDO			SUBA			
	voluntary resign	Retire ment	Death	voluntary resign	Transfer	Retire ment	Death
Doctors	3 (100%)	Nil	Nil	40%	60%	Nil	Nil
Clinical officers	Nil	50%	50%	100%	Nil	Nil	Nil
Nurses & midwives	Nil	33%	67%	8%	20%	32%	40%
Other tech. staff	Nil	Nil	Nil	100%	Nil	Nil	Nil
Casual	Nil	68%	32%	Nil	Nil	100%	Nil

4.5. Constraints and DHMT coping strategies in recruiting, deploying and retaining HRH

4.5.1. Recruitment

Constraints:

Policy restrictions and lack of adequate funds are cited by DHMTs and facilities as hindrances to recruit staff to fill up vacancies. Recruitment of health staff by DHMT is not allowed, except for casual non-technical staff. Health staff is recruited by Ministry of Health.

Coping mechanism:

As described above, DHMT is only allowed to recruit casual non-technical staff. In order to cope with the situation of lack of professional staff some of the recruited casuals are given technical tasks. For example, in a Bondo sub-district hospital CHWs carry out technical duties such as drug dispensing and administering injections. Any attempt to fill technical staff posts by using district resources did not succeed due to inadequacy of funds. *Bondo DHMT says: "We had to let a clinical officer go because the casual offer we had given was inconsistent to the HRH policy and furthermore we did not have enough money to pay him competitively".*

4.5.2. Deployment

Constraints:

Deployment within the district is another challenging task. Key hindrances to fair deployment within the district include: lack of staff houses, long distances between facilities and shopping centres, poor accessibility, lack of schools matching the class and recreation facilities required. Facility factors that are also critical in deployment include lack of hospital equipment and the heavy workload.

Majority of staff would like to work only in the District hospital which is at least within the urban centre. Deployment to facilities in the rural areas is resisted by deployed staff and even leads to staff resignations. *The hospital administrator states:*

"In Madiany Sub- District Hospital in Bondo District, a doctor who had been deployed there, reportedly took photos of the house she was to stay in, and the next time when her whereabouts were heard, she had been employed with an NGO in Kisumu".

Doctors are particularly critical about their accommodation. *According to a key informant: "Majority of the doctors come from financially well-off families. Hence for them to take housing offered at the rural centres is considered as too low a standard for their status, and it does not meet their expectation".*

With regards to the COs, inexistence of locum opportunities within the working areas is cited as the main hindrance to being stationed at a rural health facility, while for the nurses the major obstacle is distance away from their families.

Coping mechanisms:

As a coping mechanism, DHMTs have deployed to rural facilities mainly new recruits and low cadre staff. For example, Madiany Sub District hospital has more nurses because of their low rate of refusal to deployment as compared to the clinical officers and doctors.

4.5.3. Retention

Constraints:

Even though not many staff left their posts voluntarily during 2003-2007, the reasons for leaving brought up by DMO and other DHMT staff include the following.

Firstly, the overall salary package as given by the ministry is significantly less competitive compared to a number of other potential employers. Some competing NGOs (Mild may International, Centre for Disease Control) pay their staff three times as much as the MoH. Besides, most staff working for these NGOs lives in urban areas and receives daily transport to their rural work stations. In Bondo the DHMT lost their DMOH to an NGO. This DMOH had been in the district for only two months by the time of leaving public service. Private for profit health service providers also provide an alternative employment opportunity. For example, in Suba two doctors left for Aga Khan private hospital in Kisumu city and International Centre for Insect Physiology and Ecology (ICIPE). Doctors are attracted by these private organisations (whether for profit or not for profit) and appear not to be put off by the short-term nature of the contracts that are offered. Nurses on the other hand say during focus group discussions that they give preference to the security of Ministry of Health jobs, which are also less stressful.

Secondly, lack of staff housing, electricity and water contributes to staff attrition. In the Madiany sub district hospital in Bondo and in the Sindo district hospital in Suba a doctor and pharmacists left due to lack of adequate housing for them.

Thirdly, poor road infrastructure inhibited staff retention in particular at rural health facilities that become unreachable during the rainy season. Examples are Madiany sub district hospital and Mageta dispensary in Bondo district. In Mageta, for instance, the facility had to be closed since all staff had left, until some nurses employed through the Clinton Foundation were deployed there.

⁸¹ GoK Staff being hired on daily basis by other programs other than their employer (GoK) and given some allowances

Fourthly, service factors and the poor working environment, mainly unavailability of equipment and supplies, contribute to staff attrition. Staffs who find themselves in this type of facility feel under utilized, incapacitated and in some cases exposed to patient ridicule. For example, in Madiany sub district hospital before equipping the lab, the hospital used to loose clinical officers due to their feeling of incapacitation.

Coping mechanisms:

Most of the factors affecting staff retention are beyond DHMT's capabilities. However DHMT implement what is within their ability to improve working conditions, including linkages, collaboration and partnerships with other government institutions and ministries, such as local government, roads and transport, governmental development agencies (e.g. CDF) and NGOs.

In relation to staff housing, DHMTs have engaged in active partnerships with stakeholders such as CDF, Local Authority Transfer Fund (LATF) and the local county councils for funding the construction of staff housing and improvement of roads. For example in Bondo; district hospital, Madiany sub district hospital and Mageta dispensary benefited from the funds to improve the housing situation and the road network. Apart from government bodies, also NGOs such as NARESA and CDC contributed funds towards equipping, constructing and renovating health facilities.

Capacity building is another area in which DHMT collaborates with NGOs to motivate retention of their staff. In Bondo, Mild May and Liverpool VCT assisted in capacity building in HBC and VCT respectively, while in Suba FACES and IMC trained staff in HIV/AIDS management and awareness creation. In the Annual Operational Plan 3 (2007/08) DHMT in Bondo included career development for two doctors to undertake their post graduate studies.

4.6. The influence of organisations and externally funded programs on recruitment, deployment and retention

4.6.1. Faith Based Organisations and private for profit organisations

After abolishment of user fees the number of patients at FBO facilities decreased which resulted in reduced revenue. The majority of FBO facilities clients opted for no-user fee services at public health centres. General salary raise in the public sector lowered the competitiveness of employment terms at the FBO facilities, according to the in-charge of a faith based hospital in Bondo. However, in both districts the FBOs have not lost any staff to government, NGOs or to externally funded programs but expressed fear of attrition due to the factors above (in-charge Lwak Hospital).

4.6.2. Externally funded programs

Externally funded programs have both positive and negative influences on human resource conditions.

Positive influences include the recruitment of additional staff. Through the Clinton Foundation, the two districts received extra nurses and clinical officers, who are now deployed by the DHMTs to rural facilities where the shortage was worst. In the year 2006, Bondo district received 50 nurses (accounting for 76% of total overall increase of 129% for the district), while Suba district received

45 nurses (increase of 167% from 27 to 72) and 9 clinical officers (increase of 200% from 3 to 9). Bondo district also received 3 nurses and 2 peer counsellors from NARESA who have been seconded to the district hospital while IMC seconded 1 lab technician, 2 VCT counsellors and 1 nurse for the MCH clinic in a government facility in Suba district.

Externally funded programmes further enhanced staff morale in the two districts through the provision of equipment and drugs. In Bondo district, for example, CDC provided hospital equipment (CD4 count machine and malaria test kits). This boosted staff motivation. Bondo district was also a recipient of the malaria drug Coartem from CDC. Most of the staff acknowledges that it significantly improved their working conditions and hence reduced their inclination to leave the district. In Suba district, FACES and IMC supplied drugs and staff especially in the area of HIV/AIDS. The government staff working in these facilities recognize this as having improved their morale and productivity. *The Bondo DMO remarked: "Availability of the CD4 count machine has enabled the complete service delivery for PLWHA. They can now be tested and given ARVs at the district hospital, when earlier on we had to refer them to the provincial hospital. Here, we feel as a team that now we are helpful to the community".*

In addition, living conditions improved which contributed to staff motivation and satisfaction. For example NARESA constructed and renovated staff houses and a MCH facility.

Provision of locum opportunities is another motivating factor by EFPs for government staff. For instance, FACES in Suba district provide outreach programs that offers short-term working opportunities for small daily allowances to government staff that are off-duty or on annual leave.

Capacity building, FGDs revealed, has a positive influence on retention by improving competency and confidence among the government staff. EFPs conducted most on-the-job specialized training for medical staff including trainings on VCT, HBC, ARV and PMTCT/MCH supported by Liverpool VCT, Mild May, ICROSS, CDC and NARESA in Bondo. In Suba district, health workers at Sindo affirmed that they are now able to perform all the required confirmatory tests in MCH clinics. However, the concentrated focus on HIV/AIDS leads to duplication of efforts and inefficient resource utilization, according to a nurse participant during the Sindo FGD.

In addition to the positive effects, EFPs also affected negatively on the staffing situation in the districts. For example, the high salaries paid by EFPs to their staff that works alongside government employees are cited as a de-motivating factor. CDC and NARESA in Bondo district pay their staff higher salaries than similar cadres of government health workers.

Another de-motivating factor is the variation in the working terms and conditions. For example, CDC staff is employed on a working basis of 8.00am to 5.00pm with a one-hour lunch break, as opposed to staff of the FBO with whom they are working side by side. The latter have to work after stipulated working hours and must make sure that all the patients in the waiting bay are served. This was cited as a source of frustration for the facility staff, when compared with margins in their salaries versus workload.

Furthermore, some EFPs such as CDC, IMC and FACES were engaged in active recruitment of their staff from government health facilities causing high staff turnover especially among doctors. This active recruitment also affected the deployment of staff within the districts, especially to remote and rural areas where housing and other social amenities are problematic. Whereas there is no evidence that the two districts have lost any of their staff to these particular EFPs (except for CDC), all the doctors who resigned from government service while working in these districts appear to have

ended up with some NGOs. For example the immediate former DMOH of Bondo resigned for greener pastures with an NGO (although the informant did not know the name of NGO).

4.7. influence of EFPs on staff productivity

Recruitment of additional staff by external programs in the case of the Clinton Foundation has significantly reduced the workload to especially the nurses in some departments and rural facilities. This reduction in workload enabled government staff in the respective department and rural facilities to work normal hours and take their normal off-duty days. Staff feels that they are now more productive at the work place than they were before. For instance, in Bondo district hospital, there was only one nurse on duty in the medical ward who was sometimes called upon to work day and night duty whenever a colleague was sick, while at present nurses work normal hours and are able to take off duties as scheduled.

It is noted that the increased demand by EFPs for administrative tasks which involves reporting and organising workshops and seminars to launch new programs called for more hours being devoted to these tasks by the DHMT team, doctors and clinical officers. This effectively has reduced the availability of DHMT technical members' time for technical duties in district hospitals. For instance in both districts, the DMOs are now full-time engaged in administrative duties, while at the same time each district is seconding one or more of their staff members from clinical duties to coordinate GFATM activities. The consequence of this is that district hospitals, where they are supposed to deliver their technical duties, have remained with only one medical doctor. This shift due to reduction in time and staff among the DHMT members led to suspension or fewer outreaches being undertaken as compared to planned targets.

Medical Superintendents in district hospitals are also charged with the administrative responsibilities of the facilities, which –according to the medical superintendent of Bondo district hospital- take on average 30%. This leads to inadequately covered medical duties. For example *the medical superintendent of Bondo DH stated: “.....as a result, today there has not been any doctor available to provide technical support because I am fully in administrative meetings; and yesterday the same happened as I was attending a provincial meeting in Kisumu”.*

Some EFPs have played a major role in expanding the scope of health services to be provided to a client regarding specific diseases. For example, FACES in Sindo district hospital brought in new elements of data collection for research purposes. Without delivering extra staff required this increases the amount of time that staff needs to spend on one patient. Ultimately, the number of patients that can be handled effectively by staff within a given time period went down. This leads to increased work load on the staff and consequently exhaustion which negatively impacts on their productivity. On this issue *a nurse remarked: “For me, they (externally funded programs) have increased my work load. Initially without FACES there was no PMTCT, but for now, I have to go an extra mile and counsel and test pregnant women on HIV for administration of nevirapine, but before I only used to check for immunization for the children”.* However, *the medical superintendent and DMO notes that it is a positive development that these women and children are tested and the EFP cannot be blamed for workload increase but the government for inadequacy in staffing the facilities. The main concern of the two officers is that the EFPs have just like the government not addressed the staffing shortages adequately. Another health worker noted: “Before, I would take 5 minutes, but now, I take 10-15 minutes on a patient and if both the child and mother are positive, it takes at least 30 minutes”.* The implication of this is overworked staff leading to poor service delivery as remarked elsewhere in Bondo district by *a nurse in MCH department: “...this makes me*

too tired to the extent that I see patients as a bother and often use unfriendly words when attending to their problems”.

Cases where government staff is involved in EFPs that happen outside health facilities (outreach services into the community) and seminars show involved staff manipulating duty completion in order to be allowed by their seniors to go for outreach. For example, in Madiany sub district hospital, staff that is involved in Plan outreach activities rushes his /her day's work in order to solicit permission to attend to the outreaches. Similarly, in Suba sub-district hospital, IMC used the only lab technician for one full week, a situation that created a crisis in the facility. This results into reduced quality of work and double standards to the patients. Furthermore, the selectivity of Plan Kenya in Bondo district to one specific staff in a facility creates animosity among other non-participating staffs.

5. Discussion and conclusions

In Kenya it is widely acknowledged that there is a human resources for health crisis. Several interventions addressing issues surrounding human resources for health are included in HNSSP II, AOP II, draft HRH Strategy and Joint Support Program.

Key interventions operationalized by AOP II (2005/06) at district level include:

- Strengthening recruitment, deployment and redeployment processes to address attrition and staff shortages at level 2 and 3
- Reviewing health worker terms and conditions, including salaries, allowances and incentives
- Improving the planning and coordination of human resource development
- Establishing structures for coordination of human resources across the sector

These interventions are very relevant and require to be implemented at especially the district level in order to have a positive impact. To investigate more into detail the HR situation at district level, this study was carried out. The objective of the study was to analyse at district level, in what way HRH recruitment, deployment and retention are influenced by external funding and to what extent this is in line with national and district policies and strategies. To achieve this objective, the study examined in detail the government policy, trends, distribution and funding of HRH in the district as well as identification of coping strategies employed by DHMTs and the extent of influence that the EFPs have on recruitment, deployment and retention and staff productivity at the district level.

Gathering information at district level was a big challenge. In both Bondo district and Suba district, especially financial expenditures on health and human resources for health are not available. The same information could not be obtained at the central level either. While AOP II is planned and budgeted at district level, both DHMTs were not aware of any planned budget for health and could only derive figures on money transferred to the district not connecting this to planned activities. Human resources are planned centrally without input from the district. The same applies to externally funded programs at district level. Especially on their total budgets and financial sources, information was lacking. All these separate unknown flows from central level make it impossible to coordinate HR development activities at district level.

General staffing trends 2003–2007 showed that although in 2006 a big deployment of nurses had boosted the establishment in both districts, general staffing remained insufficient in relation to establishments set in 1990. Despite a government policy and interventions to improve the HRH situation in the districts, there is still a lot that needs to be done to reduce targeted chronic inequalities in staff distribution in poorly resourced rural facilities as contained in the operationalized AOP II (2005/06) at district level. Except for the big deployment of nurses, in general staff deployment and attrition were balanced. While most doctors left their posts voluntarily other cadres were mostly transferred, retired or died. The policy by GOK in 2002 to introduce payment of non practice for medical doctors, dentists and pharmacists in order to improve the situation in under-supplied areas by e.g. tripling the allowance of medical doctors was described by Mathauer and Imhoff (2006) to have attracted 500 doctors. This study shows that in major under-supplied areas such as Bondo and Suba the difficulty in attraction and retaining medical doctors still remains persistent.

The biggest DHMT constraint in HRH management is that policy restrictions and lack of funds are making it impossible to recruit new staff. Due to bad working and living conditions staff deployment and retention is challenging. In order to cope with HRH inadequacies, DHMTs adopted various strategies. Collaborations and partnerships with government agencies and EFPs were used to get some additional staff for specific units, to equip some facilities and improve housing and road infrastructure respectively.

An inventory of EFPs shows that EFPs in Kenya differ in 1) their funding modality: through MoH or not through MoH but through NGOs and 2) their HR strategy: 2a) using existing public health staff and/ or recruiting their own staff and 2b) limit staff tasks to HIV/Aids or let them implement overall general government tasks. Due to these differences in strategies EFP influences vary as well.

Only one EFP: the Clinton Foundation, channelled their funds through MoH in order to recruit additional human resources (mostly nurses) to deliver general ministry of health tasks. According to different players, DHMT staff and health workers this EFP had a very beneficial effect on the HR deployment in both districts. Direct staff hiring for deployment by DHMTs have four benefits. Firstly, it enables the DHMTs to effectively undertake deployment to hardship and rural located facilities which are the most problematic aspect with government employed staff. Secondly, it has alleviated the burden of workload in the health facilities leading to increased productivity. Thirdly, DHMTs are able to request and fill positions according to need. The fourth benefit is that since the EFPs are employing for the government facilities, they tend not to source from the public health staff, thereby eliminating the threat of competing opportunities that leads to resignation from the government service.

Although not channelled through MOH but through NGOs, also other EFPs recruited HR (CDC, FACES, IMC, MildMay, ICROSS, NARESA) which caused a positive boost to the staffing situation and morale in health facilities. However most of these EFPs used those HR mostly for HIV/Aids activities except for NARESA that employs staff to be seconded to DHMT. Overall recruitment, deployment and definition of tasks of this EFP staff were defined by EFP funders outside the purview of MoH. This limits the positive influence to a specific health facility and specific activity (HIV/Aids) and therefore may not increase capacity for DHMT priorities.

Positive influences of EFPs cited by DHMT staff and health workers in addition to increased number of staff in the districts include availability of drugs, improvement of living conditions, increase of equipment, locum opportunities and capacity building by training of staff (including staff not recruited by EFPs). Improved working conditions and equipments have increased the comfort, confidence and satisfaction of the staff about their service and boosted their morale which accordingly improves acceptance of deployments and retention.

Negative influences were created by EFPs that entirely depended on MoH staff like GFATM. In both districts, clinical officers were withdrawn from health facilities to coordinate these programmes by carrying out administrative tasks making government staff working longer hours to cope with staff shortages and increased activities. As a consequence of these, there are reported staff shortages and an overload of work leading to de-motivation of staff thus affecting their productivity. The malaria, HIV/AIDS and TB-Leprosy Programmes of GFATM are really in need of managers to coordinate earmarked activities.

Some EFPs (CDC, IMC, FACES) were actively engaged in direct sourcing of staff from the public health service sector offering better packages compared to the government package. This resulted in competition for medical staff especially doctors and clinical officers and possibly explaining the

high attrition rate among the doctor cadre due to resignation. Animosity among staff was created by EFPs that offered higher salaries and better terms and conditions to their staff in comparison to MoH staff that were used in the project to implement the same activities.

The findings of this study clearly demonstrate that the good policy intentions for HRH improvement cannot be achieved without consistency and commitment and actions of key players in the district: DHMT and EFPs. DHMT does not have the mandate and the capacity to apply a common approach to interact with EFP in order to achieve optimal positive influence on HRH. EFPs apply various HR strategies. The best strategy entails channelling funds through DHMT in order to recruit additional human resources to deliver general ministry of health tasks as done by Clinton Foundation.

6. Recommendations

It is recommended that steps be taken to ensure that more external funds strengthen the district health system. In particular the HRH situation needs to be strengthened and for this to happen it is inevitable that:

Recommendations for DHMT:

1. Develop strategic and operational HRH development plans based on carefully assessed HRH needs of the districts to form a basis for a cohesive improved HRH situation.
2. Refine and articulate their working relationships with EFPs that with a tendency to expand their capacities in recruitment, deployment and retention of their HRH
3. Plan to implement a system of constant monitoring and feedback to inform HRH optimal utilization

Recommendations for MoH:

1. Undertake assessment of district HRH development initiatives with a view to identifying and improving its action to increase the rate of achieving targeted goals
2. Strengthen DHMTs capacities to undertake HRH planning, implementation, monitoring and evaluation of their HRH for optimum service delivery
3. Learn from best practices externally funded programs that improve recruitment, deployment and retention and come up with a policy and guidelines on HRH strategy to be followed by externally funded programs ensuring consistency and efficiency.

Recommendations for EFP and other development partners:

1. Prior to implementation of their programs need to assess potential impact/ influence of their program on health service delivery especially regarding human resources to effectively undertake health activities
2. To fund HR to carry out general activities
3. CF evaluation of injection of nurses will be evaluated

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Colophon

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